07-04792	
James Brooks	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle Last) 3. Time of Death Month Day June 24, 2007 0008 hrs Medical Examiner James Brooks 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk5. Social Security Numbeunk 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. **Euneral** Foreign Country) Months Davs Hours Director Min 1 X M 2 F 85 Jan 1, 1922 Yrs Usual Residence of Decedent 10d, Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 Yes 2 No or 28a-f show MD Baltimore or items 23a or 28a-f shormust be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2509 Violet Avenue 21215 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 unk Yes No after Widowed Divorced If Yes, Give Yea Yes 2 X No specify: Specify black 3 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk pe during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 injury or other traumatic event, the Medical E College (1-4 or 5+) Comple Baltimore, MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore. MD21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other in 22 Name and Address of Facility State Anatomy I Baltimore, MD Board 2120 irector 655 W. Baltimore Street un. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and Medical Death a Smoke and soot inhalation and thermal burns Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed the attending physician and ed for use as the burial - transi Physician/Medical #28d, perME, G869, 7,28a-f, per ME,g869 Y UNPENDED #ENDED-Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown ned by the detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be þ 1 Yes 2 No 3 Probably 4 Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? this certificate has performed? Yes 2 1 🗸 Yes 2 To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: No 1 V Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Yes 2 No To the Funeral Director: completely filled in by the Pending Fnd 6/23/2007 Fnd 11:45 pm Victim of house fire 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide 2509 Violet Ave. Baltimore, MD (Specify) House Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.F. June 24, 2007 30. Name and address of person who completed cause of death (Item 23a)

Registra

31. Date filed (Month

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Margarita Korell MD. . Assistant Medical Examiner

0 2007

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Louis L. Brankovich, Jr. $\mathbf{a}^{\mathsf{M}}$ July 2007 3:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days <sup>Year)</sup> **19**28 Hours 1 XM 2 ☐ F 220-22-7636 79 July 6, Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1211 June Road 21227 U.S.A. filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give 5-44 Year or Dates: 3-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: þ Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) Baltimore Gas and College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mentai Hygien Important: If Item 27 is marked other than any Injury or other trainment. 6 Service Man Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis L. Brankovich, Sr. Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Jimenez/Step Daughter 328 T<u>unbridge Road Baltimore Maryland 2121</u>2 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery 20a. Method of Disposition 20c. Location - City or Town. State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-10-2007 Baltimore, Maryland ☐Qonation 5 ☐ Other (Specify) 22 Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus MD 21 Signature of Funeral Service Licensee 23a. Pant Enter the disease, or commic tions that caused shock, or heart failure. List on one cause on each line lions that caused for reath. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ATHEROSCI To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this Mariner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 1/2001

516

ACDS, Catonsville 21228

30. Name and address of person who oppleted cause of death (Item 23a) (Type, Print)

Year)

		4	State of Maryland / Depa	rtment of Health and M tificate of Death	ental Hygien Reg. N	otto / czella -
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
	Physicia /Medic	al	Catherine Burkhea		July 8	2007 2:15 A. M
	Examin		sa. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Laure1	4	c. County of Death Prince Georges
	F		Greater Laurel Health & Rehab.  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		216 24 3327 1 M 2 Kg F 78 Yrs.	Months Days Hours Min.	Feb. 23,	1929 Maryland
	pu k	-	Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or Loc	eation		10d. Inside City Limits
	Manyla f sho	ō	Maryland Anne Arundel Glen Bu			1 □ Yes 2 🖾 No
	r 28a	irect	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	th witi	al D	6664 Robert Court #090	21061		U.S.A.
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural; or Itams 23a or 28a-f show event, the Medical Evertirer must be notified at	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	2 hou		15 Decedent's Education 16a Deced	ent's Usual Occupation	16b.	Kind of Business/Industry
215	within 7 ene. than "n i.e.Med	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	kind of work done during most of working NOT use retired)	.9	Own Home
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Baltimore,	parmit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 W Burial 2 Cremation 3 Hemoval from State 4 Donation 5 Other (Specify)  Meadowrice	lge Mem. Park 7/10	/2007 E1	Location - City or Town, State  Lkridge, Maryland
Balt	parmit. Departr Importa any inje		Jecome monuourles 40		y Baltimo	al Service, P.A. ore, Maryland 21225
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s, P.O. Box 687	To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signad by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the un	Ectopic pregnancy Other (specify)  Inderlying cause given in Part I.		23d. Date of delivery Month Day Year  o use contribute to the cause of death?
ord	v require been sig should b	ted	Malnutrition		1 🗆 Yes	7
of Vital Records,	The law rate has be page 2 sh	Completed by			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vita	ysicien: The is certiticate hi director, page	Be	25. Was case referred to medical examiner?	Otherwise	(Check only one)	0 FOther (Constitution
of	Phys r this ral dir	. To	27. Manner of Death  28a. Date of Injury (Month, Day Year)  Notice 1 September 1 September 1 September 2 September	1 3 DOA 4 Nursing Ho	me 5 Hesidence 28d. Describe how in	6 ☐Other (Specify)
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Division	il or Attendi atter death. I Director: A d in by tha fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Phwithin 24 hours atter death. To tha Funeral Director: Atter th completely tilled in by the funeral	edical C	29a. Certifier (Check only one)   1 S Certifying Physician: To the best of my knowledge, deat 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
	To the To the Comp	W	29b. Signature and title of dertifier  M.D.	29c. License number  5 3 411	1 50	Date signed (Month, Day, Year)  ULY 09 15 2007
	IV		30. Name and address of person who completed cause of death (Item 23a) (Type. 14300 Gallowt Fox Ln # 210	Print) J Shesac BOWIE MD	ini 20715	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 1 0 2007  Security Signature	de		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** UNE Bernard Alfonso Brown /Medical 4a. Faculty Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner AINT ALTIMORG Year If Under 24 Hrs. 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 □ F Months Days Hours Min. Yrs. 54 089-44-9901 **b**3 19 53 VA Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2⁄☐ No MD Howard Woodstock 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2208 Siena Way Funeral 21163 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade T. Specialist Social Security Adm. 2yrs+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nora V. Gilliam ပ Pearly Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Brown-Wife 2208 Siena Way, Woodstock, Md 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 7/2/07 Randallstown, 21. Signature of Funeral Service Licensee 22 Name and Address of Facility March F/H West Il me 4300 Wabash Ave, Baltimore, Md 21215 Oh 23a. Part1. Ent. r the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleratic Coronary Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown feart Failure ongestive 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsv perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 XER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**Funeral** 

Director

show

r 28a-f show notified at

"natural", or Items 23a or

injury or other traumatic event, the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traument.

Physician

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Director:

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Hospital or Attending Physician:

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Physician/Medical

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Be Completed

Certification: To

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State Registrar

29b. Signature and title of certifie

4 ☐ Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D00533/2

900 Caton Avenue,

29d. Date signed (Month, Day, Year) une 27, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

enageler chelle 32 Registrar's Signature Month, Day, Year)

			State of Maryland / De 1 - State Amend #11,14,19b, perFH, g869, 7/20/07	partment of Health and Mertificate of Death		giene Reg. No.2 () ()	7 22005
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	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
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	Funeral Director		5. Social Security Number  237-54-0481  6. Sex 1	Months Days Hours Min	8. Date of Birtl (Month, Day 2 - 4 -	9. E 7. Year)	Birthplace (State or Foreign Country)
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	the M	Director	MD RAINGALL  10e. Street and Number	10f. Zip Code		10g. Citizen of What	
	3a or	ä	4056 Carthage Road	21133		U S A	Country:
	death ms 2 r mus	Funeral		3. Was Decedent of Hispanic Origin? (Spill of Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - A	nerican Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	ģ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 № No Specify:	Hican, etc.)	1 '	1ack
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Maryland	ld be file lental Hy <b>ked oth</b> ic event	To Be (	17. Father's Name (First, Middle, Last) Sanford Bowen	18. Mother's Name Henriet		Maiden Surname)	
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5	the deal	Physician/M		☐ Other (specify)		Month	Day Year
L'S'L	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affect death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			to the cause of death?
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	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the basis of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the c	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within To the comple	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mo	nth, Day, Year)
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	4		30. Name and address of person who completed cause of death (Item 23a) (Type	1838 Greene	100	, Rd	21400
	Sta		31. Date filed (Month Pag, Year) 2007 32 Registrar's Signature	rest !	1,000	0	-/ -4
	Registra	ar	La Contract of				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** July Bay ZABEDA BASSANT 2 ሽሽን 2:30 ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Greater Laurel Health & Rehab. Laurel Prince George's if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Ye 6. Sex 7. Age (In vrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□M 2□F XX Months 217-11-9865 6, Director 1930 Guyana Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🎗 📝 No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 20707 U.S.A. 7608 Brooklyn Bridge Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🖾 🗓 o Specify: þ 3 XXidowed 4 ☐ Divorced Specify: East Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Care Provider Grade 9 Health Care other event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 Is marked oth Jury or other traumatic even Be Mohamad Kasim Haleman (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zaman K. Alli 609 4th Street Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XX gurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If any Injury or once. George Washington 07/09/2007 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility al Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio-Respiratory Failure /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, leavy, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dise to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Hypertension Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth · 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Chronic Renal Insufficiency 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 🛚 🛣 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4XX ursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 ☐ X 💢 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea. Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 20251 July 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Road, Suite 220 Laurel, Maryland Gita Shah, M.D. 32. Resistrar's Signature JUL 1 0 31. Date filed (Month, State 2007 Registrar

			1 - For State Registrar	State	of Marylai	•	artment of H		d Mental Hyg	iene 007	22007
			Decedent's Name (First, Middle,	Last)					2. Date of Dea	th	3. Time of Death
	Physici /Medio		Nola Jean	Currenc	e				July	7, 2007	6:30 A M
	Examir		4a. Facility Name (If not institution,				4b. City, Town, or	Location of D	Death	4c. County of Death	
			4310 Stanwood	Avenue			Ва	ltimore	2		
	Funeral		5. Social Security Number	S. Sex	7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth Min. (Month, Day	Year) 9. Birth	nplace (State or Foreign untry)
	Director		235-44-6178	1□M 2 <b>∑</b> F	76	Yrs.			Dec. 23	, 1930 Wes	t Űirginia
	pue *		Usuel Residence of Decedent  10a. State 10b, County		10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	daryl f aho	৳	M 1								1X Yes 2 No
	the 1	Director	Maryland  10e. Street and Number				Baltin 10f. Zip Code	iore		0g. Citizen of What Cou	intry?
	3a or	Ö	4310 Stanwood A	700110				1206		U.S.	•
	death ms 2	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. \			? (Specify Yes or No- ruerto Rican, etc.)	14. Race - Amer	
Maryland 21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28s-1 ahow idical Exercinet must be notified at	þ	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed F d 1 Tes If Yes, G Year or	2 <b>K</b> ]No ive	1	fYes, specify Cuba I□Yes 2∏X No	n, Mexican, P Specify:	ruerto Rican, etc.)	Black, White	, etc. hite
0	0 4 4	Completed	15. Decedent's (Specify only highest		1		lent's Usual Occup		Lucation	16b. Kind of Business/l	
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21		Con	12				Homema	ker		Own Hor	me
nd		Be	17. Father's Name (First, Middle, L.	ast)				18. Mother's	Name (First, Middle,	Maiden Sumame)	
<u>Y</u> a	D 2 2 0	은	Cleothus Hart			_			lva Cross		
Ja	2 sho		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	g Address (Street	and Number o	r Rural Route Number	r, City or Town, State, Z.	ip Code)
	s 1 and 2 shoul f Health and M Itam 27 Ia marl other traumati		Cheryl Jones (I	aughter)			antern La	ane, St		Pennsylva	
Baltimore,	6 O _ L		20a. Method of Disposition 1   Burial 2 □ Cremation :	Removal from	State	cemetery, cren	natory or other plac		Date	20c. Location - City or 1	own, State
‡	t. Pa		4 ☐ Donation 5 ☐ Other (Spe		Ma	plewood	Cemeter	y 107/	/10/2007	Elkins, We	st Virginia
Bal	permit. Pag Department Important: I any injury o		21. Signature of Fuherel Service L	ognsee -		9	705 Bela:	ir Roac	Schimunek B I, Baltimon	Funeral Home e,Maryland	e Inc. 21236
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that nly one cause on	caused the dea each line.	th. Do not ent	er the mode of dyin	g, such as car	rdiac or respiratory arr	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Ca	ona	u a	terno	dis	2000 4	Ranalfe	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quento of):	10	- (	1.20	1/05	<i>t</i> )
		e e	Sequentially list conditions, if any, leading to immediate	b. Duate	(or as a conse	s ///	ellul	e, C	OFD	Hy poed	when
$\overline{\iota}$	ted nsit	in in	Cause (Disease or injury	La la	(or as a conse	quence on.		/		0.0	
	be executed sicien end burial-transit	Examin	that initiated events resulting in death) Last	Due to	(or as a conse	quence of):	use				
8760,	cate be ex ohysicien the burial	dicai		d							
9	g phy as th	edi							110 -		
.O. Box	it the death certificate be executed by the attending physicien end iached for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐No 9 ☐ Unknown	1 🗀 Live	atcome of pregn birth 2 Fet nant at time of a nown	al death 3□	Ectopic pregnancy Other (specify)		NB	23d. Date of deli Month	very Day Year
۵.	\$ 8 g	by Pt	Part II. Other significant condition	s contributing to	death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P.	requires seen sign hould ce	0							1)X(Y	es 2□No 3□Pro	bably 4 Unknown
Records,	> 11 th	Complete							24a. Was a	n 24b. Were aut	opsy findings available
	9 9 9	E O							autops	med? death?	ompletion of cause of
ta	certifical rector, p	0	25. Was case referred to medical					26 Place of	1 ☐ Yes :	2 No 1 Yes	212/140
$\geq$	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 █ ਅਰ	Hospital:	Inpatient 2	] ER/Outpatien	t 3□ DOA Oth		11	ence 6 Other (Spec	utv)
0			27. Manner of Death	28a. Date		28b. Time of Injury	28c. Injun Worl			ow injury occurred	,,
Ö	Attanding r death. actor: After	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	in, buy rour,	Injury	M 1 🗆	Yes 2/1 No			
Division of Vital	or A fiter Street in by	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 286. Plac	e of Injury - At h ling, etc. (Speci	nome, farm, stro	eet, factory, office		28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical Ce	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the	e best of my kn	owledge, death	occurred at the time	ne, date and p	place, and due to the concurred at the time.	ause(s) and manner as late and place, and due	stated.
	thin 2.	Medi	29b. Signature and title of centrier	// and mar	nner stated.		29c. License				
)	To with		b // //				i) Y	5475		29d. Date signed (Month	, vay, ivai)
	10		30. Name and address of person w	no completed cau	se of death (Ite	. 1		2.2			
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Sign		RFORD	ED			
	Registr		IIII 1 A	2007 /		H ha	ratio				
DIL	MU 17 Day 1/0	201	JULIV	2001	all the s	157					

ORIGINAL

OK as is per ME

	•	For State Registrar	ricas	State of M		d / Dep	eartment of Fertificate of	lealth and N			2007	22000
Physicia /Medic		1. Decedent's Nam Mary E	ne (First, Middle, Evelyn	,					2. Date of D Month June		Ž007 <sup>Year</sup>	3. Time of Death 6:50 A M
Examin		4a. Facility Name (I	If not institution,	give street and number)			4b. City, Town, o	r Location of Death		4c	. County of Deat	
		Stella					Timor				Baltimo	
Funeral Director		5. Social Security N 212-09-4 Usual Residence of	4326	6. Sex 7. Aç 1 ☐ M 2 ☐ 1 7. Aç	ge (In yrs. Ia 83	-	Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth (av, Year) 5, 1	913 Mar	hplace (State or Foreign Lyland
and w		10a. State	10b. County		10c. City	, Town or L	ocation					10d. Inside City Limits
Maryl f sho	ŏ	MD	Balti	more		Tin	nonium					1 □Yes 2 No
r 28a	Director	10e. Street and Nu	ımber	<u></u>			10f. Zip Code			10g. Cit	lizen of What Co	untry?
h with		2300 DUI	lanev Va	lley Road			2109	93		1	United S	States
ms 2	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S	3. 13	. Was Decedent of I- If Yes, specify Cub		pecify Yes or N		14. Race - Ame	rican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	δ	1 <b>∐K</b> √ever Marr 3	ried 2☐ Marrie 4☐ Divorced	Armed Forces?  1 Yes 2 1  If Yes, Give Year or Dates:	No		1 ☐ Yes 2 X No	an, Mexican, Puerto	o Hican, etc.)		Black, White Specify: Wh	e, etc. nite
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hould d Mei mark matic	٩	19a. Informant's N	lame/Relationshi	n (Tyne Print)	CIAL	1	ling Address (Street					Zin Cada)
nd 2 s Ith an 27 is r trau				, Guardian			W. Chesar					'
tem 2	ŀ	20a. Method of Disp	position	•		ace of Disr	osition (Name of	· · · · · · · · · · · · · · · · · · ·	Date	<u> </u>	ocation - City or	
Page: ent o nt: If i			☐Cremation : 5 ☐ Other (Sp.	3 □Removal from State			ematory or other place ley Menoria		05/2007	Timor	nium, Mary	vland
mit. F	1	21. Signature of Fu	1	1								Services of
permi Depar Impor any Ir		> Ultre	11211	W								onium, MD 21093
Physician /Medical Examiner		23a. Part1. Enter t shock, or hee Immediate Cause disease or condition resulting in death)	artfailure. Listo (Final on	emplications that cause only one cause on each li a. ue to (or as	ne.	stai	1	ng, such as ciudiac	-	arrest,		Approximate Interval Between Onset and Death
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death certificate I attending physi	Physician/Medi	IF FEMALE: 23b. Was deceden		23c. If yes, outcome	pf pregnai	ncy death 3	□Ectopic pregnancy	v			23d. Date of del	ivery
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w requires that the d been signed by the should be detached	ρ	Part II. Other signi	ficant condition	ns contributing to death b	out not resu	Iting in the	underlying cause giv	ren in Part I.		-		the cause of death?
To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed									s an opsy formed? 220 No	prior to death?	itopsy findings available completion of cause of
certific ector,	Be	25. Was case refer examiner?	rred to medical	[			laii	26. Place of Dea	th (Check only	one)		
Physical this call direction	2	1 Yes 2					ent 3 DOA Oth	4.20 Nursing H			6 □Other (Spec	cify)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Deat  1. Natural  2  Accident  3  Suicide	5 Pending investiga 6 Could no	ot be 28e. Place of inj	ury - At ho	28b. Time Injury me, farm, s	Wor	y at k? Yes 2 □ No	28d. Describe	Í		ural Route Number,
spital or nours afte neral Dire		4 ☐ Homicide  29a. Certifier	1 2 Certifying	Physician: To the best	of my knov	vledge, dea	th occurred at the ti	me, date and place	and due to the	own, State	and manner as	stated.
thin 24 l	Medical	(Check only one)	2 ☐ Medical E	xaminer: On the basis of and manner st	of examinat	ion and/or i	nvestigation, in my o	opinion, death occu	rred at the time	e, date an	d place, and due	to the cause(s)
T virit		29b. Signature and	A Inter of Certifier	esting 1	2	MK	29c. Licens	3274	(0)	Ja Da	ite signed (Monti	9 9 M 2007
3				ho completed cause of $GHT$ , $M$ $.D$ $.$		1	, Print) L <b>ANEY VA</b> L.	LEY ROAD	TTT	MONII	IM MD	21093

31. Date filed (Month, Day, Year)

32. Registrar's Signature JUL 1 0 2007 1. Sports

State Registrar

6:50 A.M.

Baltimore, Maryland 21215-0036 JUNE 29, 2007

Division or Vital Records, P.O. Box 68760, <

CLARKE, MARY

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_		Registrar	/Final 84istal	In 1 and			Cei	rtificate	OT D	eatn	0.0-1	Reg. N	lo.	Ĭ.		JUJ
Physicia	an	1. Decedent's Name		e, Last)							2. Date of De Month	D		ear	3. Time o	
/Medic		Marie Co						41: 02: T.			July	9,	2007		3:54	Рм
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Funeral	9	5. Social Security Nu		6. Sex			last birthday)	If Under 1 \ Months D		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth av, Yea	(r) 9	Birthpl	lace (State	or Foreign
Director		278 14 85		1  M 2	ALF	84	Yrs.		,,.		Jan. 15	,19	23 W		Virgi	inia
and W		Usual Residence of 10a. State	Decedent 10b. County			10c City	, Town or Lo	cation						14	0d. Inside C	Situ Limito
sho sho	'n	Maryland	Balti			100.00,	_							'		2X No
the N 28a-f	Director	10e. Street and Num		TIOLE			Ess		- 1 -			40- 0	Distance of 14th -	10000		
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uld b Venta rked tic e	To	Harry And	erson							Collie Wi	illiams					
sho and h s ma		19a. Informant's Na	me/Relations	ship (Type. Prir	nt)		19b. Mailir	ng Address (S	treet an	d Number or Rur	al Route Numl	er, City	y or Town, Sta	ate, Zip	Code)	
and and alth		Brenda Ha	.11 (Da	ughter	)		22 Ye	w Rd. 1	Balt	imore, N	Marylan	d 2	1221			
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Pag nent ant: I		4 □ Donation			i from State	<sup>e</sup> Bay	view C	remato	ry	7/10/	2007	B	Baltimo	re,	Mary	land
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service	License	()	1)	22	2. Name and	Address	of Facility	1 77	D 7				
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/Medical		resulting in death)		a		s a consequ		با حر	- 0	MENUM	ι				0412.	
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w requires that the d been signed by the should be detached	F.	Part II. Other signifi	icant conditi	one contribution	a to death	but not resu	ulting in the u	adodvina ozus	eo divon	in Part I	230 Did	tobago	o use contribu	uto to th	of	doath?
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chys this a	2	1  Yes 2 1 1		Hospital	1 🔲 Inpai		ER/Outpatien		Other:	4 LI Nursing Ho				(Specif	y)	
ling F After uner	Certification:	<ol> <li>Manner of Death</li> <li>Natural</li> </ol>	5 Pendir	ng	Date of In (Month, D	jury Pay Year)	28b. Time of Injury		. Injury a Work?		28d. Describe	how in	jury occurred			
teath tor: the	cat	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not ho	Diam.			М		es 2 No						
or A	=	4 ☐ Homicide	determ	nined 28e.	building,	njury - At ho etc. <i>(Specif</i> )	me, farm, str //	eet, factory, o	office		28f. Location City or To	(Street wn, Sta	and Number ate)	or Rura	d Route Nur	mber,
pital		29a. Certifier	1 M Cartiful	na Physician	To the hea	at of many leads	ulodao doot		Ale e Aires e	4-4			( )			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)	2  Medical	Examiner: Or	the basis d manner s	of examina	tion and/or in	vestigation, in	my opi	e, date and place, nion, death occur	and due to the red at the time	e cause e, date a	e(s) and mann and place, and	er as si	tated. o the cause	(s)
o the	Mec	29b. Signature and	title of certifie		d manner s	stated.		29c. L	icense r	number		29d F	Date signed (	Vonth	Day Year)	
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Sta	te	31. Date filed (Mont	th, Day, Year	I VCa	32. Regis	rat's Signa	ture	602	De	LIQUE ICO	L. Da	LITI	more	1	W 61	1236
Registr			JUL	. 1 0 20	07 1	Page in	· Ma	Arack		lair Re						
HMH 17 Rev 1/20	001	<u> </u>			200	المعدادة المراجعة والماسات	= 25 m/g	STANGE						_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** HIEKO 07 2007 COMMOR /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner UNIVERSITY OF S. Social Security Number 215-34-8302 LEDICAL CENTER BALTIMURE if Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Country) Director March Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Baltimore Funeral Director Maryland 1'XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 E. Madison Street, Apt. 711 21205 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Japan ese 1 ☐ Yes 2 🕱 No Completed by 3 ¥Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clothing Elementary/Secondary (0-12) College (1-4or 5+) Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be tem 27 Is marked Masakichi Uchida Hana Hana ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Hammett-Daughter 1503 West Lexington St. Baltimore, MD. 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 12 20c. Location - City or Town, State 20a. Method of Disposition July permit. Pages Department of Important: If Its 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Garrison Forest Veterans 007 4 Donation 5 Dother (Specify) 21. Signature of Fuperal Service Licenses 22. Name and Address of Fagilians Funeral Service, P.A. Calvin D.O. Box 11651 Baltimore, Maryland Baltimore, Maryland 2/239 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LIVER FAILURE **Physician** /Medical Due to (or as a consequence of): Examiner CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. if yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐ Pregnant at time of death 9☐ Unknown Month Dav Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 □ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 2 ER/Outpatient 3 DOA this Director: After the in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and of certifier 2 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

30. Name and add

31. Date filed (Month, Day, Year)

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TIMORE,

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ess of person who completed cause of death (Item 23a) (Type, Print)

0 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 ear **Physician** July 5, 9:26 Cicero Рм Pasquale /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 M 2 □ F 83 328-38-1860 Director March 6,1924 Italy Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show a or 28a-f sho t be notified a 1 ☐ Yes 2X No Directo Maryland Harford Street 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Italy 21154 4370 Federal Hill Rd. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√€ No Specify:White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates other than "natu vent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M Bethlehem Steel Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gugliuzza Vincenza 2 Cicero Antonino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4370 Federal Hill Rd. Street, MD 21154 Anthony Cicero / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 Trother (Specify) Entombment Bel Air Mem'l. Gdns. 7/9/07 Bel Air, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 610 W. MacPhail Rd. Bel Air, MD 21014 Inc. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Immediate Cause (Final Physician veeres resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) ☐Yes 2☐No been signed by the s should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has irector, page 2 autopsy 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ပ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this Olca 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;

completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar

JUL 1 0 2007

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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N. Charles St. Balto. Md 2(20)

		-	For State Registrar		State of	Marylan	•			eaith and i D <i>eath</i>	vientai Hy	Reg. No.	(c) =1 mg	
8			Decedent's Name	(First, Middle, Last)	)						2. Date of D		Year	3. Time of Death
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	Examin		4a. Facility Name (If I	not institution, give	street and num	ber)		4b. City		Location of Death			ounty of Death	
	18- <u> </u>		NOETHN		OSPITAL	7 Ann //m 1880	la at hirthday	If Unde	RAW!	If Under 24 Hrs.	8. Date of Bi		BAT, M	o & E lace (State or Foreign
l.	Funeral Director		5. Social Security Nu. 201–18–94	53 <sup>1</sup>	м 2 🗶	7. Age (In yrs. 82		Months		Hours Min.	May 1	ay, Year)	Cour	nsylvania
	ryland thow		Usual Residence of D 10a. State	10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits 1 ☐ Yes X No
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	with tu	Ö	10e. Street and Num	ston Road				10t. Z	p Code 2120	7	т		n of What Cour	of America
	ns 23	Funeral	11. Marital Status	CON ROAG	12. Was Dece	dent Ever in U.	S. 13. 1	Was Dec		ispanic Origin? (S an, Mexican, Puerl			. Race - Americ	an Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Ď	1 ☐ Never Marrie		Armed For 1 ☐ Yes If Yes, Giv Year or Da	Ð				an, Mexican, Puèri Specify:	io Rican, etc.)		Black, White,	
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Jar	2 sho		19a. Informant's Nar				1		,	and Number or Ru				'
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mor	Pages nent of int; If Its iry or o		1X Burial 2 □	Cremation 3 ☐ F  Other (Specify)			cemetery, cres Ld R1d;				07/07	Pikes	ville,	MD. 21208
Baltimore,	permit. Departn Importa any inju		21. Signature of Fur	Service Licens	ee		2:	2. Name 6	and Address	ss of Facility Lor	ing Bye	rs Fur	neral Di	irectors,Inc
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g	Examine	<u>a</u>	Sequentially list con	ditions,		or as a conse		7	dee	are				
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68760,	ficate be executed physician and is the burial-transit	edical			d			_						
	E Dig		IF FEMALE:		23c. If yes, out	come pf pregna	ancy					23	d. Date of deliv	erv
.O. Box	he death conthe the tending	Physician/M	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	1 ☐ Live b	irth 2□Feta ant at time of c	al death 3	⊒Ectopic ⊒ Other (	pregnancy specify)	/			Month	Day Year
S, P.	w requires that the di been signed by the should be detached	y Ph	Part II. Other signifi	cant conditions co	ntributing to de	ath but not res	ulting in the u	nderlying	cause giv	en in Part I.	23e. Dio	tobacco use	e contribute to t	he cause of death?
rds	quires en sign uid be	ed by	_ Clast.	iden diff	rule C	ouris					1	Yes 2	No 3☐ Pro	bably 4 □Unknown
or Vital Record	2 SS 2	Completed									24a. Wa	is an	24b. Were auto	opsy findings available empletion of cause of
Ä	The ate h page	Som									per	formed? 2'⊊No	death? 1 ☐ Yes	
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7	Physician: this certific ral director,	မှ	1 ☐ Yes 2 1021	40			ER/Outpatie			4 □ Nursing I	1		☐Other (Speci	fy)
ou C	ding F	ion:	27. Manner of Death	5 Pending investigation	28a. Date (Mont	h, Day Year)	28b. Time o Injury	M M	28c. Injur Wor 1 □	yat k? Yes 2 □ No	28d. Describe	e now injury	occurred	
Division	Attending r death. ector: After by the funer	ficat	2 ☐ Accident 3 ☐ Suicide	6 Could not be determined	28e. Place	of injury - At h	ome, farm, st			100 20.00			Number or Rur	al Route Number,
ă	s after al Dire	Certification:	4 ☐ Homicide		Duridi	ng, etc. (Speci	(y)				City or 1	own, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (		1' <b>⊠ C</b> ertifying Phy 2  Medical Exam	iner: On the b									
	To the within 24	Med	29b. Signature and	title of certifier				2	9c. Licens	e number		29d. Date	signed (Month	Day, Year)
	d		1	Wat a ton	k ins				D/	0059736		9	uly 3	2007
	10		30. Name and addre	s of p son who c		e of death (Iter	n 23a) (Type,	Print)		7-0		do		-
	10		O EBORA H	MATISM		MEICK	MD	, ne	RIHN	EST HO.	SPITAL	540	0100	COURT ROAD
	Sta Registr		31. Date filed (Mont	h, Day, Year) II 1 0 200	201	egistrar's Sign	ature	1803						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 18, 2007 8:50 A. Josephine Cala 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Baltimore Franklin Woods Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 8. Date of B 7. Age (In yrs. last birthday) 96 vrs 9. Birthplace (State or Foreign 5. Social Security Number Mary Tand 1 □ M 2 🔀 F 213-60-4695 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Baltimore 10b. County Baltimore Mary land 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 2540 Holly Neck Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giovanna Culotta Pasquale Liberto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2540 HollyNeck Road Baltimore Maryland 21221 Rita M. Stoval/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/11/07 Baltimore Maryland Most Holy Redeemer 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Thc. 5305 Harford Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADJERDICATO DISFASE MEADT 3d Date of delivery Month Day Year e contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 40

29d. Date signed (Month, Day, Year)

BALTIMORE,

Physician /Medical Examiner

permit. Page Department of Importent: If eny injury or once.

**Physician** 

/Medical

Examiner

10a. State

Funeral Director

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Completed

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Funeral

Director

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hygiene. orient: If item 27 is marked other than "naturel, or items 23a or 28a-f show injury or other traumatic event, It w M-dical Ex. miner must be notified at

Baltimore, Maryland 21215-0036

burial-transit attending physician as the ed by the a been signed by t should be detach after death Director:

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

	resulting in death)	Due to (or as a conseq	juence of):	<i>t</i> −−− <i>t</i>	4 (2)	
er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):	74		
cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	juance of):			
by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	al death 3 Ectopic preg		2	23d. Date of delivery Month Day Year
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Completed					24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death? 1 ☐ Yes 2 ☐ €0
Φ	25. Was case referred to medical			26. Place of Dea	th Check on one	
To B	examiner?	fospital: 1 Inpatient 2	ER/Outpatient 3 □ DOA	Other: 4 ursing H	lome 5 Residence	3 □Other (Specify)
rtification: 7	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	i, Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
ertifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory, ofy)	office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )

Registrar

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within 24 hours a To the Funerel [

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29a, Certifie

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31. Date filed (Month

29b. Signature and title of certifier

PARSHAL

Day, Year)

JUL 1 0 2007

FRANKLIN

and address of person who completed cause of death (Item 23a) (Type, Print)

9105

Registrar's Signature

💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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QUARE DR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July Nancy Morrison Conrad 2007 4:30 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Blakehurst Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🛛 F July 25, PA Director 196-16-1171 85 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10b. County 1 ☐ Yes 2 ☐ YNo Director Baltimore Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 1055 W. Joppa Road # 628 21204 LISA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
sint: If item 27 Is marked other than "natural", or items 23s and it if item 27 is mander other than "natural", or items traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ō No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify White 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pianist Performer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell J. Morrison Nellie E. (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau William Conrad (son) 303 Brentford Road, Haverford, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hillton Svc. Corp. 07/09/2007 4 □ Donation 5 □ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson MD 19041 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, o Immediate Cause (Final disease or condition resulting in death) **Physician** MUMON Nells /Medical Due to ( as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ed by the atter in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 ☐Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 certificate 1∏ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nonce 1 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 | Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 | Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the for investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death $J_{uly}^{Month}$ 4, 2007 8:45P M Genevieve Debus 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Glynn Taff Assisted Living Catonsville Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 92 Months Days Hours Min 1 □ M 2 🗓 F 215-09-5700 Nov. 3, 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 No Director Maryland Baltimore Lansdowne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 618 Washington Ave. 21227 USA Be Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Supervisor Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Andryscak Bernard J. Doniecki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Dennis Debus, Son 1131 Valley Drive Pasadena, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park 07-10-07 Elkridge, MD 4 ☐ Donation 5, ☐ Other (Specify) 21. Signatur, of Funer 22. Name and Address of Facility Ambrose Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21227 Arbutus, Approximate Interval Between Onset and Death Immediate Cause (Final rojective tallure cont several years disease or condition resulting in death) Due to (or (s) consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse quence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted Living 1 ☐ Yes 2 📉 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Division or Vital Records, P.O. Box 68760, physician for use certificate has been signed by the rector, page 2 should be detached funeral director. n 24 hours arer death.

The Funeral Director: Af Stetely filled in by the fun To the Hosp within 24 hor To the Fune completely fi

**Physician** 

/Medical

Examiner

**Funeral** 

Director

iral", or Items 23a or 28a-f show Exa⊓iner must be notified at

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or iten Iny or other traumattc event, the Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

Physician

/Medical

**Examiner** 

Saltimore, Maryland 21215-0036

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier Ciletner Kaja MD

29a. Certifier

29c. License number DQ7541

29d. Date signed (Month, Day, Year) July 6,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ferry Rd Suite 4A, Bulhmary, MD-21227 RAJA MD, 4367 HOllins 31. Date filed (Month Pay, Year) 2007

State Registrar

Medical

32 Registrar's Signature

and manner stated.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/19a per INF. G869 7/13/07 WS.
State of Marviand Penantment of Health and Mental Hygiene

			State of Maryland "Dep 1 - State Communication Communicati	artment of Health and Nertificate of Death	lental Hygier Reg. I	2	22017
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Evelyne K. Dreyer				3. Time of Death  1:00 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)  IVY Hall Geriatric Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death  Middle River    H Under 1 Year	8. Date of Birth (Month, Day, Yea	4c. County of Death  Baltimore  9. Birthp Coun	lace (State or Foreign
	Director		220-03-1802 1 □ M 2 X F 95 Yrs.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	113.11.10	05/30/19	912   Mar	yland Od. Inside City Limits
	ith the Maryla or 28a-f shov	Director	Maryland Baltimore Essex  10e. Street and Number  808 Sue Grove Road		10g.	Citizen of What Coun	1 □Yes 2 X No
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If Item 27 is merked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at	by Funeral Director		. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Americ Btack, White, Specify: Whi	etc.
21215-0036	filed within 72 ho Hygiene. other then "natur ent, 'ne Wedical	Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)  Clerical  18 Mother's Name	king	o, Kind of Business/Indo  OX Manufac  den Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the M	To Be	17. Father's Name (First, Middle, Last) Henry Slicer Cross  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Flore	nce Coll	lett	Code)
Baltimore, Ma	permit. Pages 1 and 2 si Depertment of Health an Importent: if litem 27 is r any injury or other traur QDG8.		Nancy E. Kennedy (Friend) 740  20a. Method of Disposition  1 Surial 2 Cremation 3 Removal from State  4 Denation 5 Other (Specific)  Loudon	Sue Grove Road E	ssex, Mary Date 200 10/2007 F ruzdzinski	yland 212 : Location - City or To Baltimore, Funeral H	own, State  Maryland  ome PA
38760,	hysicien end physicien and phy	dical Examiner	23a. Part 1. Emprithe disease, or complications that caused the death. Do not expected the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68	death certiff e ettending d for use as	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	B ☐ Ectopic pregnancy  □ Other (specify)	23a Did tohac	23d. Date of deliv Month	Day Year
	e law requ has been ye 2 shoul	Completed by	Part tt. Other significant conditions contributing to death but not resulting in the	funderlying cause given in Part I.		2 No 3 Prol	bably 4 Unknown  opsy findings available impletion of cause of
Division of Vital Records,	fing Physicien:  After this certific funeral director.	Certification; To Be C	25. Was case referred to medical examiner?  1	Other: 4 A vursing H	28d. Describe how	et and Number or Rur	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the i	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de Check only one)  Certifying Physician: To the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	urred at the time, date	and place, and due	to the cause(s)
1	F 3 F 8	_	30. Name and address of person who completed cause of death (Item 23a) (Ty	29c. License number D-3875  De, Print)  2457EAN BLU	2 1	7-09-	221
_	St Regist	ate	MHLIKA WASPAIN. 709. 6  31. Date filed (Month, Day, Year)  32. Begistrar's Signature	badi	1 - 10	,	

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 6, **Physician** Wilma Pearl Stine Davis 2007 8:55 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 6311 Joyce Drive Camp Springs Birthplace (State or Foreign Country)
 Penn 8. Date of Birth (Month, Day, Year) Oct 18, 1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2□F Yrs. 90 577 14 5690 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a State 10b County 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Camp Springs Maryland Prince George's Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 20748 United States 6311 Joyce Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 🏋 0 Specify: Specify White ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Attornev Federal Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Heelth and Mental is ant: If item 27 is marked o Elizabeth Pearl Heline Wilmer Evert Stine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6311 Joyce Drive, Camp Springs, MD 20748 Kent Davis (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of the important: If its any injury or of once. 1 ☐ Burial 2 【\*\*\* Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 7, 2007 Clinton, Maryland Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Segice Licensee 20735 Alexandria Ferry Road, Clinton, MD strant mo0257 ones Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONTH CONFESTIVE HEART FAILURE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ned by the ettending physicien and deteched for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ PNEUMONIA ASPIRATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No DEMENTIA s certificate has b lirector, page 2 sl 1 ☐ Yes 2 No : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No М by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direc I Direc 4 Thomicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28281 JULY 6,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BENJERS, 9131 PISCATAHAY & ICLINTON, MJ 20735 NELSON 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Robert J. Driscoll 2, 2007 July 10:50P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Stella Maris Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1X M 2 □ F 034-28-6428 68 Director 4-30-1939 MA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Exa⊓iner must be notified at MD Baltimore Dundalk 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7009 Dunmanway, Apt. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No "natural", or Specify: Specify: White ğ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "Important; or other traumatic event, the Med any Injury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 12 Cab Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Scopa Mary Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blaine Driscoll - Son 337 S. Bouldin St., Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 7-3-07 4 Donation 5 Dother (Specify) Baltimore, MD 22. Name and Address of Facili Bradley-Ashton Funeral Home 21. Signature of Funora 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition met astatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier ca Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be exec Records, Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate It BE or Vital Division 24 hours a within 2

with the Maryland

50:0

200

land 21215-0036

Mary

Baltimore,

State Registrar 31. Date filed (Month, Day, Year)

JUL

1 0 2007

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY Day Year 2007 01:25M F **Physician** 8, Anthony Lewis DiMarco /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 219-01-0837 Director 1/24/1921 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show notified at MD 1 ¥Yes 2 □ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e "natural", or items 23a dical Examiner must b 6613 Eastern Parkway 21214 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White <u>8</u> 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than " Elementary/Secondary (0-12) College (1-4or 5+) Property Manager 10 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 is marked of traumatic even Gabriele DiMarco Catherina DeVita ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. Mary Lou Healy / Daughter 1505 GreenDale Road Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 7/12/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5305 Harford Road 21. Signature of Euneral Service Licensee Wells Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK HOURS /Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE 2 HOURS Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ASPIRATION PNEUMONIA 8 HOURS attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ILEUS DAYS Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ACUTE RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown SEVERE ISCHEMIC CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has b irector, page 2 sl autopsy 1∐ Yes 2**X** No 1 ☐ Yes 2□ No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) ↑ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 🗖 Naturai 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation ours after death. neral Director: / death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifiei 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on

State Registrar

BARR, LINDA F. 31. Date filed (Month, Day, Year) JUL 1 0 2007

30. Name and andress of

one) 29b. Signatur

> M.D. Registrar's Signature

of death (item 23a) (Type, Print)

7505 OSLER DRIVE, #409, TOWSON.

D35453

29c. License number

Date signed (Month, Dav. Year)

MARYLAND 21204

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1830 **Physician** 07 4a. Facility Name (If not institution, give street and number) Ervin ewis /Medical 4b. City, Town, or Location of Death Balto. Md. Batto C Examiner arkway If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M M 2 ☐ F 8. Date of Birth (Month, Day, 09-23 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days **Funeral** Months Hours Min. 227-18-3268 Director Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at Baltimore 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? Street and Number W.C death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 17 es 2 No 17 yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or item 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be OFtis Ervin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Baltimore mo permit. Pages 1 and 2 s Department of Health ar Importent: if item 27 is any injury or other treu QDG. Magnolia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 7-12-0 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licens MD 2/239 to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, real failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Deh droho Due to ras a consequence of): weeks Physician /Medical Examiner Chami dianher Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Juisease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed 3years attending physician and for use as the burial-trans Colon canon resulting in death) Last Due to (or as a consequence of) been signed by the should be detached ģ Be Completed

Division of Vital Records, P.O. Box 68760 To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p Certification; To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery  Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Chronic real for	whie	1 Yes 2 No 3 Probably 4 Unknown
DM recovered UTE		24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☐ 1√0	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1 ──Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury 28b. Time of 28c. Injury at Work?  Injury M 1 Yes 2 No	8d. Describe how injury occurred
3 Suicide 6 Could not be determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Continuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 3/29 5

Suite 4202

29d. Date signed (Month, Day, Year)

21204

7/9/07

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medicai

31. Date filed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



6701

Charles St

			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 0 0 7 2 2 0 2 2
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Lgerton  2. Date of Death Month Day Year 7 5 AM  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director		Genesis Cromwell Center  5. Social Security Number  1. Social Security Number  2. Social Security Number  2. Social Security Number  3. Social Security Number  4. Social Security Number  5. Social Security Number  7. Age (In yrs. last birthday)  8. Date of Birth  (Month, Day, Year)  Aug. 4, 1931  9. Birthplace (State or Foreign Country)  Maryland  Usuaf Residence of Decedent
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Iteme 23e or 28a-f show any injury or other traumatic event, Ira Madical Exactified main be notified at once.	To Be Completed by Funeral Director	10d. Inside City Limits   10d. Inside City
8760,	Medical Examiner hysicien and hysicien are hybridized by the hybridized hybridi	cai Examiner	23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death disease or condition resulting in death)  a. Carolica work of the condition resulting in death)  Due to (or as a consequence of):  Is charted a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  AGCVD  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  AGCVD  Due to (or as a consequence of):  AGCVD  Due to (or as a consequence of):
P.O. Box 68	it the death certific by the attending p tached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Year
Vital Records, F	The law requires tha ete has been signed page 2 should be de	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  End Stock Venel as Sease  1 yes 2 No 3 probably 4 porknown  24a. Was an autopsy performed?  performed?
Division of Vital	ding Physician:  After this certifice funeral director,	Certification; To Be Co	25. Was case referred to medical examiner?  1
Div	To the Hospitel or Attent within 24 hours efter death To the Funerel Director: completely filled in by the	Medical Certi	29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
)	To the within To the Comp	Me	29b. Signature and title of certifier  Proceeds May  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  Proceeds Proceeds May 29d. Date signed (Month. Day, Year)  7/5/2007
	5 Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CORN WILL CENTEN 8710 GM6E RD BALTIMORE MD 21234  31. Date filed (Month) Pay, Year) 2007  32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #7,8,perFH,C869,7//18/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 1612 pM FROTHING HAM JOYCE 2007 5 ULV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MAYLAND MEDICAL GENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 22, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Min. Days 1 M 2 TF Washington, D.C. 216-52-7540 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 No Director MD Kent Galena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with ō þe USA 21635 113 Dogwood Drive items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. r than "natural", or iten the Medical Examiner 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: White þ 3 ☐ Widowed 4 🏋 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Battaile Orrock James Burton Carrico ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Dogwood Drive Galena, MD 21635 Margaret Frothingham/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 07/09/07 Beltsville, MD 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251 Reverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the dis-shock, or heart fail .... Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCAR914L INFACTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine g physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical as attending IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Box 68760. P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Pleath.

To the Funeral Director; After the completely filled in by the funeral

State Registrar

SMYDER GRAH44

(Check only one)

29b. Signature and title of certifier

1983

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

22 S. GREENE BALTIMORE MD 2120

32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

Nnaemeka

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Agajelin

Physician

**ORIGINAL** 

29d. Date signed (Month, Day, Year)

2007

MD. 8094 Edwin Raymor Brid Site A Paradeng MD 2112

<b>1 -</b> For State Registrar	State of Maryland	Certificate of			leg. No.	9909;
1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
Physician William Dexter	Fowler			July	2 2007	9:55 p M
Examiner 4a. Facility Name (If not institution, give s		4b. City, Town, o Laurel	r Location of Death		4c. County of Death	
6104 Parkway Driv			if Under 24 Hrs.	8. Date of Birth	0 Dieth	place (State or Foreign
Director 249-44-1776 X	M <sup>2□ F</sup> 74	Yrs. Months Days	Hours Min.	(Month, Day 1/27/1	933 Sout	h Carolina
Usual Residence of Decedent  10a. State 10b. County		y, Town or Location				10d. Inside City Limits 1 ☐ Yes 2☐No
MD Prince Ge	orge's Lau	10f. Zip Code		1	10g. Citizen of What Cou	
6104 Parkway Driv	'e	20707			United Sta	tes
the death status 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No 195	52- If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specific	, etc.
S s not feel MXWidowed 4 Divorced 15. Decedent's Educ	cation Year or Dates: 197	16a. Decedent's Usual Occur	pation	. (	16b. Kind of Business/I	ite
275.12-0036  and within 17-0036  and within 17	completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire) Chief of Secur		ang	Johns Hopk	ins A.P.T.
12 17. Father's Name (First, Middle, Last)		Chief of Secur		e (First, Middle,	Maiden Surname)	1110 1111111
The state of the s	aler		Mabel F	Katherin	e Burch	
To Father's Name (First, Middle, Last)  17. Father's Name (First, Middle, Last)  18. Clyde William Fow  19a. Informant's Name/Relationship (Tyl  Anita Holbrook/	*	19b. Mailing Address (Street 6104 Parkway				ip Code)
O 0 0 - 1 17 Nourial 2 Cramation 2 D	omoval from State	Place of Disposition (Name of cemetery, crematory or other place Lincoln Ceme	ce)	Date /2007	20c. Location - City or Brentwood,	,
The property of the property o	ee/ M00770	22. Name and Addre	*	Home, P.	A. 313 Taib	MD 20707 ott Ave.
23a. Part1. Enter the disease, or compli shock, or heart failure. List anly or	cations that caused the deat	h. Do not enter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
Physician Immediate Cause (Final disease or condition		Senile Dementia			i i	Onset and Death
/Medical resulting in death)  Examiner	Due to (or as a conseq	uence of):				
Sequentially list conditions,	Due to (or as a conseq	uence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter underlying that initiated events resulting in death) Last	·					
figure 1 and	Due to (or as a conseq	juence of):				
physicia be physicia is the burner care but the burner care care care care care care care ca	i					
X to the plant of	Sc. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 □ Ectopic pregnanc	<b>Э</b>		23d. Date of del Month	ivery Day Year
	ntributing to death but not res	sulting in the underlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to Yes 2□No 3□Pr	3/3/
Vital Records, P.O.  Stellar The law requires that the speen signed by the law requires that the law requires the law requires the law requires that the law requires the law requires that the law requires the law requires that the law requir				24a. Was autop perfo 1□ Yes	an 24b. Were au prior to o death? 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ntopsy findings available completion of cause of 2KKlo
OF Vita of the state of the st	Hospital:	Ot	26. Place of Dea			
A E B F OZ Moment Dooth	28a. Date of Injury	28b. Time of 28c. Inju			dence 6 Other (Spe	city)
1.2 Martine of Death   1.2 Martine   1.2 Mar	(Month, Day Year)		Yes 2 □ No			
* Fare 4 Hounda	28e. Place of injury - At he building, etc. (Specifical Control of the control of	ome, farm, street, factory, office fy)		28f. Location (S City or Tox	Street and Number or Ru wn, State)	ural Route Number,
egypour special specia	iner: On the basis of examina	owledge, death occurred at the ation and/or investigation, in my				
T 4 T at one)	and manner stated.					
On the first of t	and manner stated.	29c. Licen	se number		29d. Date signed (Mont	h, Day, Year)
To the Hours at to To the Property one)  29a. Certifier Check only 2 Medical Examinate one)  29b. Signature and title of certifier one)	M Illus	111	se number		29d. Date signed (Mont	
29b. Signature and title of certifier  30. Name and address of person who compared to the comp	M Um  mpleted cause of death (iter	MI) D 3	9532		July 3, 20	07

			For State Registrar	State	of Marylan			of Hea of De		Mental Hyg	giene ()	The state of the s	22025
П	# Obviolai		1. Decedent's Name (First, Midd					,		2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic	al	ALBERTA			F-0	ULK	-62		JULY		vear	3:30 PM
	Examir	_	4a. Facility Name (If not institution						ation of Deatl		4c. County o		
	*		FUTURE CAR					_	ERSTU				ORE
(a)	Funeral Director		5. Social Security Number $556-26-5391$	6. Sex 1 ☐ M <b>X</b> X F	7. Age (In yrs. 89	last birthday) Yrs.	Months Months		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day June 4	, 1918	9. Birthpli Count Ca 1	ace (State or Foreign ry) ifornia
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 00	ty. Town or Lo	antina					10	d. Inside City Limits
	ath with the Marylar 23e or 28e-f show	tor		imore		Reist		wn				10	1 □Yes XXNo
	r 28a	lrec	10e. Street and Number				10f. Zip	Code			10g. Citizen of W	hat Count	ry?
	th with	a	6313 Deer Pa	rk Rd.				211	36		U.S	. A .	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28e-f show important: if Item 27 is marked other than "natural", or Iteme 23a or 28e-f show any follury or other traumatic event, tra Medical Exertinal intelliged at ADGE.	by Funeral Director	11. Marital Status  1 Never Married 2 Mar	Armed F	ive		Was Decede f Yes, speci X 1 □ Yes 2	X	nic Origin? (S lexican, Puerl pec <i>ify:</i>	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- America , White, e	etc.
215-0036	hour tural	ed b		Year or	Dates:	16a, Dece	dent's Usual	Occupation			16b. Kind of Bus		
15	n "na	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	(Give	kind of worl DO NOT us	k done durin e retired)	g most of wor	rking			,
212	d within giene. er then	Completed	Elementary/Secondary (0-12)		4	Н	ome M	laker			Own	Hon	ne
	at Hyg	ge C	17. Father's Name (First, Middle					18.		ne (First, Middle,		•	
yla	ould b Ment warked	To Be	George Erne		hell,					h Helen			
Maryland	12 sh h and h is m		19a. Informant's Name/Relation Mary Griffin		htor		-			Reiste	-		
e,	1 and Healt em 2		20a. Method of Disposition	. / Daug		100			K Ku.	Date	20c. Location - 0		
Baltimore,	ages nt of l t: If It		XX Burial 2 Cremation		II ŞIALU	Place of Dispo cometery, crei			 				
Ein	artme prtan Injury		4 ☐ Donation 5 ☐ Other (3		MD					the same of the sa			Mills, MD
Ba	Departing Portion		1 de la	1 June	1116								s,MD2111
	\$ 35°		23a. Part1. Enter the disease, of	r complications that	caused the deat								Approximate Interval Between
	Physician /Medical		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a		PSIS		<u>-</u>					Onset and Death
5.	Examiner	1	Sequentially list conditions,	b									
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events	- Due to	o (or as a conseq	quence or):						-11	
	al-tra	xar	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	quence of):							,
8760,	cate be executed obysicien and the burial-transit	call		d									
9	tificat g phy as th												
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pre	nnancv			23d. Date		•
-	e dea the att	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		gnant at time of d		Other (spe				Mon	th	Day Year
P.0	that the de ned by the a detached t		Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying ca	use auven in	Part I	23e. Did to	phacco use contri	hute to th	e cause of death?
Records,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burtal-transit	ed by									′es 2□No :		. /
000	law re as bee 2 sho	Completed								24a. Was autop	an 24b. W	ere autop	sy findings available appletion of cause of
Ä	ding Physician: The law n. Atter this certificate has E funeral director, page 2 s	E O								perfo	med? de	eath?	
Vital	Physician: r this certifica ral director, I	Be (	25. Was case referred to medical examiner?						Place of Dea	ath (Check only o	ne)		
of \	Physic this c	2	1 ☐ Yes 2 ☐ No		Inpatient 2	ER/Outpatier	-		Nursing H	lome 5 Resid	ence 6 Othe	r (Specify	)
n c	ding F h. After tunera	on:	27. Manne if Death 1 Natural 5 Pendi	''9	e of Injury onth, Day Year)	28b. Time of Injury		Bc. Injury at Work?		28d. Describe h	ow injury occurre	d	
isic	Attending r death. ector: Atter by the funer	cat	3 Suicide 6 Coufd	not be 200 Black	ce of Injury - At h	omo farm et	M		2 🗆 No	28f. Location (S	Street and Numbe	ror Pum	Pauto Number
Division	al or A after I Dire d in by	Certification:	4 Homicide determ	nined 200. Flac	ding, etc. (Specif	fy)	eer, ractory,	once		City or Tow		r or nurar	Houte Number,
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurred a vestigation,	it the time, d	late and place on, death occu	o, and due to the dirred at the time, d	cause(s) and man date and place, a	ner as stand due to	ated. the cause(s)
	Total	Σ	29b. Signature and title of certific	Br /			29c.	License nui	mber		29d. Date signed	(Month, L	Day, Year)
	1			14	- M.P	>	D.	517	22		JULY	9 2	.007
į	0		30. Name and address of person	ARDSON 1	W.D. 18	24 60	EENE	TRE	E ROAL	#300	PIKESVIL	LE A	10 21208
	Sta Registr		31. Date filed (Month, Day, Year JUL 1	2007	Registrar's Signa	athie	W						

		-		epartment of Health and N Certificate of Death		liene <sub>eg. No.</sub> 2007	22027
			Decedent's Name (First, Middle, Last)		Date of Deat     Month	th Day Year	3. Time of Death
	Physicia /Medic	_	Hilda S. Flickinger		July 7,	2007	2:20 A. M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
ю,	)+		Montgomery General Hospital	Olney	O Data of Divide	Montgomer	y hplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	r, Year) Co	untry)  Carolina
	Director		242-20-0683 Bull Residence of Decedent		Sept. 5,	1917 North	1 Carorina
	land ow at		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Man,	io	Maryland Montgomery Derwood	1			1 ☐ Yes 2 📆 No
	th the	Director	10e. Street and Number	10f. Zip Code	1	log. Citizen of What Co	untry?
	23a cust b		5612 Foggy Lane	20855		nited State	
	tems ter m	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
20	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	ite
3	tural		15. Decedent's Education 16a.	Decedent's Usual Occupation	1	16b. Kind of Business/	
	nin 72 n "na Medic	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing		
7	d with giene er tha the I	Completed		partment Manager			artment Store
	be filed within 72 hours after death with the Maryland Hylgiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)			Maiden Surname)	
2	Ment Ment arkec aric e	7	David Lloyd Keener	Lillie Re			
Z Z	2 sho		Total Information Value of Control of Contro	Mailing Address (Street and Number or Rul			
บ้	1 and Health em 27 ther t	1	20a Method of Disposition 20b. Place of		Dod, Mar	20c. Location - City or	
2	ages nt of 1 :: If ite	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	y, crematory or other place)	3 2007 1	Rockville,	Marvland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inopartment of Health and Mental Hygiene. Inopartment of Health and Mental Hygiene. Inopartment if them 27 is marked other than "naturali", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Lensee	Name and Address of Facility		- Control of the Cont	and the same of th
0	Departiment of the second of t	Ø. V	M00896	300 W. Montgomery A			
ı			23a. Part1. Enter the disease, or complications that caused the death. Dor shock, or heart failure List only one cause on each line.				Approximate Interval Between
	Physician	0 1	Immediate Cause (Final disease or condition	3/5			Onset and Death
	/Medical		resulting in death)  a.  Due to (or as a consequence of the consequenc	of):			
	Examiner		Sequentially list conditions b. PNEO	MONIA			DAYS
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):			
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last  C	of):			
00/0	cate be executed physician and the burial-transit	alE					
200	ficate g physics the	edical	0.		-	//	
X Q Q	n certi	sician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	2 DEctoric programov		23d. Date of de	
0	death e atte	icia	1 Yes 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
5	at the by th	Phys	9 Unknown		one Dida	-b	a the agues of dogth?
<u>'</u>	sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		obacco use contribute t Yes 2□ No 3□ P	robably 4 Hunknown
Records,	requi	Completed by	althal persulation of crown	A T			
ec	e law has b e 2 sl	nple	pulmonoy disease, bronchie	clasis, hipelianse	24a. Was autop	an 24b. Were a prior to death?	utopsy findings available completion of cause of
	n: The		Ostopolosin	V	1□ Yes	2 1 Ye	
VII	siclar certif	Be	25. Was case ref_rred to medical examiner?  1 ☐ Yes 2 ☐ NO  Hospital: 1 ☐ Impatient 2 ☐ ER/Ou	26. Place of Dea	11	one dence 6 □Other (Spe	noifu)
0	Physer this	2	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at		how injury occurred	schy)
0	nding th. r: Afte e fune	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	njury Work? M 1 ☐ Yes 2 ☐ No			
JIVISION	Atternation of the state of the	ific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (5 City or Tox	Street and Number or F wn, State)	Rural Route Number,
5	tal or rs afte ral Dir led in	Certification:			0		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only)  1 ☐ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination an	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	e, and due to the arred at the time,	cause(s) and manner a date and place, and du	is stated. ue to the cause(s)
	thin 2 the 1	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
	Z <u>1</u> ¥ Z ⊗		MARADADA OLA CECUA	MD D005763	0	07-07	1-2007
,	10		30. Name and address of person who completed cause of death (Item 23a)			0101	
	(			Ave.#209, Silver St	oring. M	aryland 20	902
	Sta		31. Date filed (Month) 23. Year) 32. Registrar's Signature	Sportin			
	Regist	rar		1			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1451 /Medical 4c. County of Death, 4b. City, Town, or Location of Death **Examiner** CENTER BITAL If Under 1 Year | If Under 2 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F 164-03-1851 Director 89 01/27/1918 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Examiner must be notified at MD N/A BALTIMORE 1 ¥ Yes 2 □ No Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 23a 4164 LABYRINTH ROAD 21215 Funeral U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death vale perment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the Medical Examiner must 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ▼ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College\_(1-4or 5+) **SECRETARY** GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY ၉ <u>Braverman</u> <u>ELIZABETH</u> DWORIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONARD FRANKFORD / SON 22 WALDRON AVENUE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 07/08/2007 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt Cennso 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PREUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, physician attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an page 2 s autopsy performed (es 2 IA Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 1 Hinpatient this funeral 27. Man of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death. I Director: A d in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifie

ORLANDO

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BNANAT

Règistrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $\operatorname{July}^{\scriptscriptstyle{\mathsf{Month}}}$ 2ÒÖ7 10:45 p м Charles Gillman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1190 W. Northern Parkway, Apt. 731 N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, SEP 26 **Funeral** Days Hours 1 XM 2 □ F New Jersey Director 217-38-0850 96 1910 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits r 28a-f sh 1 TYYes 2 □ No Director MD N/ABaltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or Items 23a or 3 1190 W. Northern Parkway, Apt. 731 21210 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 N Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 Widowed 4 Divorced "natural", White Completed The Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than 5+ Dentist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Gillman Anna 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21210 19a. Informant's Name/Relationship (Type. Print) Helen Gillman - wife 1190 W. Northern Parkway, Apt. 731, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/9/2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Societies H. <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, Inc. Williams HU 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mont45 JUER /Medical Due to (or as a consequence of) Liver Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending property for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsv performe 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person 1190 W. No.
32 Registrar's Signature W. Northern Pkwy #101, Bultimore Md 21210 31. Date filed (Month, Day, Year) State JUL 1 0 2007 Registrar

			State of Maryland / Department of Health and In State Registrar  State Certificate of Death	Mental Hy	giene Reg. No.	7 22030
			Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
	Physici /Medi		Patricia Ann Grandle	O party	08 20	07 8:05AM
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City Fown, or Location of Death  FRANKIIN SQUARE HOSPITAL  4b. City Fown, or Location of Death  KOSCOOLE		4c. County of D	hmore
	Funeral Director		5. Social Security Number 6. Sex 7. Mge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 24 F 58 Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da Jan. 8	rth ay, Ye <i>ar)</i> 1 Q / Q	Birthplace (State or Foreign Country) aryland
			Usuat Residence of Decedent	pair.o,	I J T IV	
	death with the Maryland ms 23a or 28a-f show finust be notilited at	'n	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Nottingham			10d. tnside City Limits 1 ☐ Yes 2 점 No
	the Maryla r 28a-f shov	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	
12	23s or	0	26 Glen Way 21236		USA	
(3)	ter death Items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S)	pecify Yes or No		merican Indian,
11/1 036	₩ 2 E	by	Armed Forces?  1 Never Married 2 Married  1 Yes, Specify Cuban, Mexican, Puerto  1 Yes, Sive Year or Dates:	o Hican, etc.)	1	White etc. White
C Sign	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	king	16b. Kind of Busine	ess/Industry
121	d within 72 hours piene. r then "naturel", the Madical Exe	Completed	Elementary/Secondary (0·12) College (1·4or 5+) Electronic Funds		Banki	ng
4 / 5	Hys H	Be Co	Transfer recuircian		, Maiden Sumame)	
	Q & D .	To B	John Markowski Ruth	Long		
Many	and and m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			e, Zip Code)
G.	1 an Heali em 2 ther		Warren Gary Grandle (Husband) 26 Glen Way Nottingham 20a. Method of Disposition (Name of	o, Maryl Date	and 21236 20c. Location - City	or Town. State
nor	of T		Description   3 December   State   Community   Communi	007		re, Maryland
Baltii	permit. Pag Dapartment Important: i eny injury o		21. Singular of Funeral Service Licen see  22. Name and Address of Facility Bruzdzinski Fun	eral H	ome P.A.	M4 21221
	_	0	23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each tine.			Approximate
0	Physician /Medical		Immediate Cause (Final disease Condition a. Metastatic Breast Caresulting in death)	ncer		Interval Between Onset and Death
	Examiner		Sequentially list conditions  Due to (or as a consequence of):  Acute Renal	faile	ire	
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
ć	execu in and ial-trar	Exan	that initiated events c. Due to (of as a consequence of):			
8760,	cate be executed physician and the burial-transit	dical	d		<del> </del>	
99 ×	entifica ding pt	Med	IF FEMALE:			
. Box 68	ie death certific the ettending p hed for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No		23d. Date of Month	delivery Day Year
P.O	that the deed by the detached	Phys	9 Unknown	20. Bid		
Division of Vital Records, P.O.	or Attending Physician: The law requires that the death certific ther death. Director: After this certificate hes been signed by the ettending p in by the tuneral director, page 2 should be detached for use as	ted by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?  Probably 4 Unknown
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ital	ician: Th certificete ector, pag	BeC	25. Was case referred to medical 26. Place of Dea	1 ☐ Yes		Tes 2 No
> =	hysician: this certific al director,	To		ome 5 Resi	idence 6 Other (	Specify)
ou o	ding Ph After th funeral	ion:	27. Manner of Death  1 ON Autural 5 Pending (Month, Day Year)  2 Accepted investigation  28a. Date of Injury (28b. Time of the top o	28d. Describe	how injury occurred	
visio	Attendi r death. ector: A by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)			r Rural Route Number.
۵	spitel or Atten ours effer deal nerel Director: filled in by the				wn, State)	
	To the Hospitel within 24 hours e To the Funerei Completely filled	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur  and manner stated.	, and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
	2		154/36		1-083	200/
	U		30 Name and a dress of person where pleter cause of death 1 = 23a) (Type, Print)  in hamlun suyeung 1000 manklun square  31 Date filed (Month Day Yasar)  32 Refutate Signature	Drive,	"baltime	112, md 21231
	Sta Registr		31. Date filed (Month, Day, Year) 32. Redistrar's Signature  JUL 1 0 2007			

			For State	e of Maryland /		it of Health and e of Death		giene	7 22031
*	Physici		Decedent's Name (First, Middle, Last)	therine	K Ho	rtnett	2. Date of Dea Month	Day	Year 3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give street and	(NSING CE	4b. City,	Town, or Location of D	oeath 1 7 move	4c. County of	
Ž.	Director		219-18-0752  Usual Residence of Decedent  10a, State 10b. County	02	wn or Location		Hai Ji	., 1723	10d. Inside City Limits
	Maryla s-f shor	tor	MD Baltimore	loc. Oily, 10	Catonsv	ville			1 ☐ Yes 2 🔏 No
	with the	Funeral Director	10e. Street and Number	/LD	10f. Zij	21228		10g. Citizen of Wh	nat Country?
	ns 234	eral		Decedent Ever in U.S.	13. Was Dece	dent of Hispanic Origin crify Cuban, Mexican, P	? (Specify Yes or No-		- American Indian,
5-0036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at	þ	1 Never Married 2 Marned 1 1	d Forces? ′es 2 <mark>反</mark> No s, Give or Dates:	If Yes, spe		ruerto Rican, etc.)	Specify:	, White, etc. white
15-0	"natur	Completed	15. Decedent's Education (Specify only highest grade comple		(Give kind of wo life. DO NOT L	ork done during most of	working	16b. Kind of Bus	iness/Industry
2121	d within	omo	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	account			McKesso	n Churchill
aryland	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. Is marked tall Hygiene. Is marked that then "natural", or liems 23a or 28a-f show aumatic event, the Martical Examinar must be multiled at	To Be C	17. Father's Name (First, Middle, Last) William Klasmeier				Name (First, Middle, ginia Gol	Maiden Sumame dsboroug	
Man	d 2 sho th and i 7 is mu traume		19a. Informant's Name/Relationship (Type, Print Patricia M. Hartnett,	cicter in		s (Street and Number of son Street)			
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic once.		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal 1  4 □ Donation 5 □ Other (Specify)	20b. Place ceme	of Disposition (Natery, crematory or Cathedral	me of other place) Cem. 7	Date /10/07	20c. Location - C	City or Town, State
Baltir	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee	mer	22. Name a	nd Address of Facility of Catonsv ville, Md.	Sterling A	shton Sc , 1630 E	hwab Witzke Edmondson Ave.,
	Physician		23a. Par1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	hat caused the death. D on each line.	o not enter the mo			rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	şr	Sequentially list conditions. b	e to (or as a consequence e to (or as a consequence	efic e	ncepho	clopath	<b>Y</b>	months
8760,	ate be executed hysicisn and the burial-transit	ilcai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequenc		1			
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	s, outcome of pregnancy ive birth 2 Fetal dea Pregnant at time of death Jnknown				23d. Date Mon	e of delivery th Day Year
	w requires that been signed t should be det		Part II. Other significant conditions contributing	to death but not resulting	g in the underlying	cause given in Part I.	23e. Did t		bute to the cause of death?  3 Probably 4 Unknown
l Records,	The law requate has been page 2 should	Completed by	anemia (typerlipiden	11/2			24a. Was autor perfo 1 \( \text{Yes}	osy pr prmed? de	Vere autopsy findings available rior to completion of cause of eath?
Vita	ician: certific rector.	Be	25. Was case referred to medical examiner?  Hospital:				Death Check only		
Division of Vital	ading Phys th. : After this s funeral di	tion: To	27. Manner of Death 28a.		Outpatient 3 D  D. Time of Injury  M	28c. Injury at Work? 1 Yes 2 No		dence 6 Othe	
Divis	al or Attar s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, building, etc. (Specify)	, farm, street, facto	ry, office	28f. Location ( City or To		er or Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) Certifying Physician: 1 2 Medical Examiner: On and		and/or investigatio	n, in my opinion, death		date and place, a	and due to the cause(s)
)	With Com	×	29b. Signature and title of certifier	7/mo	29	Oc. License number	91	July	09, 2007
	20		10(1)(0)	o Benson	Avenu	Le, Balt	Limove,	Maryl	and 21227
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Locale			•	

			1 - For State Registrer	State of M	aryland			t of H	lealth a	and M		giene Reg. No.	007	22032
Н	Physic	an	Decedent's Name (First, Middle								<ol><li>Date of De Month</li></ol>	ath Day	Year	3. Time of Death
	/Medi		George	W.		Hen	drix				JULY	05	2007	
	Examir	ner	4a. Facility Name (If not institution,	,					Location of	of Death		4c. Co	ounty of Death	1
		•	Morningside Hou				1	nove					e Arun	
	Funeral Director		239-10-7247	6. Sex 7. Ag 1 XM 2 ☐ F	le (In yrs. la 89	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Oct. 18	th ly, Ye <i>ar)</i> 3 <b>,</b> 1917	9. Birth Cou	pplace (State or Foreign intry) NC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Limits
	be filed within 72 hours after death with the Maryland that Hygliene. od other than "natural", or Items 23a or 28a-1 show event, the Medical Examinar must be notified at	ō	MD Anne A	runde1	Glen	Burni	ie							1 ☐ Yes 2 ☑ No
	28a-	Funeral Director	10e. Street and Number			Darin	10f. Zip	Code	_			10g. Citize	n of What Cou	
	with Sa or	<u>a</u>		1										2110 y .
	ns 23	era	7123 B & A B1vc	12. Was Decedent	Ever in U.S	13 \	210		snanic Ori	nin? (Sne	cify Yes or No	U.S.A	Race - Amer	ican Indian
10	r Iten	Fun	1 ☐ Never Married 2 🔀 Marrie	Armed Forces?			f Yes, spec	ify Cuba	n, Mexicar	i, Puerto F	cify Yes or No Rican, etc.)		Black, White	
38	urs a		3 ☐ Widowed 4 ☐ Divorced	ed 1 XYes 2 □ I If Yes, Give Year or Dates:			1 □ Yes 2	oN XIS	Specify:			S	pecify: Wh	ite
21215-0036	2 hou	Completed by	15. Decedent	s Education		16a. Deced	dent's Usua	I Occupa	ation			16b. Kind	of Business/I	ndustry
215	- 78	ple	(Specify only highest Elementary/Secondary (0-12)	Grade completed)  College (1-4or 5	54)	(Give life. i	kind of wor DO NOT us	rk done d se retired,	luring mos )	t of workin	ig .			-
21	filed within Hygiene. Ither than ent, the Net	E O	10	College (1-40)	,,	Mast	ter Cl	hief	Pett	y Of	ficer	U.	S.Navy	•
p	al Hy othe	Be C	17. Father's Name (First, Middle, L	ast)							(First, Middle,	Maiden Su	ımame)	
<u> a</u>	should be filed withir nd Mental Hygiene. marked other than matic event, the M	70	George W. Hend	rix					Ethe	1 L.	Friday	7		
Maryland	2 should be f and Mental H is marked of aumatic eve		19a. Informant's Name/Relationsh								Route Numbe			ip Code)
	요물성류		Mrs. H. ELizabe	th Hendrix/	Wife	7123	B & A	A Bl	vd. G	len l	Burnie	MD 21	061	
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Demoval from State	20b. Pła	ace of Dispo	sition (Nan	ne of ther place	9)	July	y 9.	20c. Loca	tion - City or T	own, State
Ĕ	Pages ment of H ant: If ite ury or of		'4 □Donation 5 □Other (Sp		Mary	y1and	Veter	rans	Cem.			Crow	nsvill	e, MD
alt	permit. Pag Department Important: b any injury o		21. Signature of Funeral Service L	icensee		22	. Name an	d Addres	s of Facilit	y Sing	gleton	Funer	al Hom	e, P.A.
_	90 E 2 9		- July	MULL M	2140	19 1	Secor	nd Ar	venue	SW (	Glen Bu	rnie,	MD 21	061
п			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused only one cause on each li-	the death.	Do not ent	er the mode	e of dying	g, such as	cardiac or	respiratory ar	rrest,	Û	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	-a. ADVA	wet	· ^	DE	nta	1710	63				Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	ence of):	200							
И	Examiner		Sequentially list conditions.	b										
	p #	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):								
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C										
8760,	death certificate be executed e attending physician and at for use as the buriat-transit		rouning in doutin East	Due to (or as	a conseque	ence of):								
	physics the b	dlcal		d										
9 ×	death certifica attending ph for use as t	/Med	IF FEMALE:	225 16 1100 0140000					-					_
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal o	death 3	Ectopic pre					230	<ol> <li>Date of delivers</li> <li>Month</li> </ol>	rery Day Year
	the a	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ith 5∟	Other (spe	ecify)						- =,
P.O	law requires that the das been signed by the 2 should be detached		Part II. Other significant condition	s contributing to death b	ut not result	ting in the ur	nderlying ca	ause dive	n in Part I		23e Did to	obacco use	contribute to	the cause of death?
ds,	signe d be	d by	PROSTATE					-000 g			101			bably 4 □Unknown
Ö	w require been sign should b	ete										- 1		
3e	0 7 0	Completed									24a. Was		4b. Were aut prior to co	opsy findings available ompletion of cause of
	ician: The certificate harector, page										1 ☐ Yes	2.7 No		2 No
V.	Physician: this certificaral director,	Be	25. Was case referred to medical examiner?	Hospital:				. Othe	-		(Check only o		- AS	513760
of	Phys this ral di	. To	1 ☐ Yes 25 No 27, Manner of Death	1Inpatie		R/Outpatien 28b. Time of		^	4 🗆 Nu		e 5 Resid	-	_	W121VING
S	ding h. After fune	tlon	1 KNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	M	Bc. Injury Work	? ′es 2 ⊡i		od. Describe I	low injury o	CCUITOU	
S	Attending r death. sctor: After by the fune	lica	3 ☐ Suicide 6 ☐ Could no	ot be	ury - At hom	ne farm stre			03 2 01	-	Rf Location (S	Street and N	lumber or Ru	al Route Number,
Division	or A after Dire	Certification:	4 ☐ Homicide determin	building, etc	. (Specify)	, iaiii, 3(ie	ot, raciory,	, onice			City or Ton	vn, State)	ornografi tra	arrioute reambor,
_	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the best	of my knowl	ledge death	occurred s	at the tim	e. date an	d place, ar	nd due to the	Cause(e) an	d manner ac	heter
	24 h 24 h 8 Fur etely	edical	(Check only 2 Medicel E	xeminer: On the basis of and manner sta	examinatio	on and/or inv	estigation,	in my op	inion, deal	th occurre	d at the time,	date and pla	ace, and due	to the cause(s)
	ompl	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date s	igned (Month,	Day, Year)
			Mungy 1	nd				1)5	753	/		JULY	05	2007
1	7		30. Name and address of person w	ho completed cause of d	eath (Item 2	23a) (Tyne 1							-	
6	V		30. Name and address of person w  Michael N (9)  31. Date filed (Month, Day/Fear)	BGOI Veten	ans /	Ywy.	Sere	te z	24 1	m'L	leasur	the,	MD	21108
	" Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signatu	re								
	Registr	ar	JUL 1 0		15	Gos	M.							

		1 - For State Registrar		aryland / I	Departme Certifica				eg. No.	22033
Physici /Medi		1. Decedent's Name (First, Middle, La  JANET E. JENNI						2. Date of Deat Month JULY	8, 2007	3. Time of Death 8:15 P.
Examir	men make	4a. Facility Name (If not institution, given	e street and number)		4b. City		ocation of Death	1	4c. County of Deatl	
- *	A CONTRACTOR	OAKCREST CARE C 5. Social Security Number 6.5		e (In yrs. last bi	nthday) If Und	PARKV er 1 Year   I	TLLE f Under 24 Hrs.	8. Date of Birth	BALTIM 9. Birti	ORE
Funeral Director			C N ORXE	83	Yrs. Months		Hours Min.	8. Date of Birth (Month, Day, 4/16/1	924 MAI	nplace (State or Foreig untry) RYLAND
yland now		10a. State 10b. County		10c. City, Tov	n or Location					10d. Inside City Limit
e Mar ta-f si	ctor	MD BALTIM	ORE	PARK	VILLE					1 ☐ Yes 2 ☐ 💢
ior 28	Director	10e. Street and Number			10f. Z	ip Code		1	log. Citizen of What Co	untry?
e 23e	erai	8820 WALTHER BLV	D. APT. 2		13 Was Dag	212		pacify Yas or No.	USA 14. Race - Ame	ncan Indian
ther de	Funeral	11. Marital Status 1 ☐ Never Married	Armed Forces?					pecify Yes or No- o Rican, etc.)	Black, White	
72 hours after death with the Maryland natural, or Iteme 23e or 28e-f show dical Examinar must be notified at	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 XNo	Specify:		Specify: W	HITE
72 ho	Completed	15. Decedent's E (Specify only highest gr		16a	Decedent's Us (Give kind of w	vork done dur	on ring most of wor	king	16b. Kind of Business/	Industry
within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5 2 YEARS	+)	HOMEMA		•		OWN HOM	F)
Hygie Hygie other		17. Father's Name (First, Middle, Last			HOMEMA		8. Mother's Nar	ne (First, Middle,		<u>ت</u>
ld be ental ked c	To Be	ANDREW TOLLEY					FLORA	BOOZE		
shou and M s mar umat	-	19a. Informant's Name/Relationship	Type, Print)	19	b. Mailing Addre	ss (Street and	d Number or Ru	ıral Route Numbei	r, City or Town, State, 2	Zip Code)
and 2 valith a n 27 ls er tre		ROBERT L. JENNIN	GS, SR./HU		8820 WA		BLVD.	The second secon	7 PARKVILL	
of He of He fiten		20a. Method of Disposition	Removal from State		of Disposition (N acc. cremators of VALLE		1		20c. Location - City or	
Pag ment ent: I ury o		4 Donation 5 Other (Special	COCKEYSVIL	LE, MD						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygnene. Importent: if tiem 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Lice	nsee			and Address LOCH R	of Facility TH		N FUNERAL I	HOME, P.A. 1286
Medical Examiner  Asicien and e purial-transit	cal Examiner	disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence a consequence a consequence	of:	110+	ion	seas e		
The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat	h 3 ⊟Ectopic 5 ☐ Other (				23d. Date of del Month	ivery Day Year
w requires that theen signed E should be deta	d by P	Part II. Other significant conditions		-		-	in Part I.		bacco use contribute to es 2 €No 3 □ Pr	
The law rec sate has bee page 2 shou	Somplete	prosthetic	age à	tic u	alve			24a. Was a autop perfor	sy prior to death?	utopsy findings availa completion of cause
ilcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?						ath (Check only or		
Physician: r this certifica ral director, p	2	1 Yes 2 No	1	ent 2 ER/C					ence 6 Other (Spe	city)
	ation	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		Time of Injury M	28c. Injury a Work? 1 ☐ Ye	es 2 🗆 No	28d. Describe ii	ow injury occurred	
nding I ath. r: After e funera	()	3 Suicide 6 Could not leadermined	28e. Place of Inj building, et		farm, street, fact	ory, office		28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
s after death. I Director: After	Sertific		,			ad at the time	, date and place	and due to the d	cause(s) and manner as	
Ne Hospital or Attending In 24 hours after death.  Funeral Director: After aletely filled in by the funeral	edical Certification:	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis o and manner st	examination a	ge, death occurre ind/or investigation	on, in my opir	nion, death occi	urred at the time, t	date and place, and due	s stated.  to the cause(s)
To the Hospital or Attending I within 24 hours after death.  If o the Funeral Director: After completely filled in by the funeral process.	Medical Certific	29a. Certifier 1 (Y Certifying P	miner: On the basis o	examination a	ind/or investigati	on, in my opir 29c. License r	nion, death occi		29d. Date signed (Mont	to the cause(s)
To the Hospital or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	Medical Certific	29a. Certifier (Check only one)  1 □ Certifying P 2 □ Medical Exa	miner: On the basis o	f examination a	ind/or investigati	on, in my opir 29c. License r	nion, death occi		29d. Date signed (Mont	to the cause(s)
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical Certification	29a. Certifier 1 D Certifying P (Check only one) 2 Medical Exa	miner: On the basis o	f examination a ated.	ind/or investigati	on, in my opir 29c. License r	nion, death occi			th, Day, Year)

Janet Jennings 7/8/07 8 15/07

hysicia								2. Date of Death	1 10 1		3. Time of Death	
	an	1. Decedent's Name (First, Middle, Last)						Month	Day	Year		
/Medic	al	John Joseph Joyce  4a. Facility Name (If not institution, give s			4h City	Town orlor	cation of Death	July 5,		y of Death	3:30 p <sup>N</sup>	
Examin	er	St. Elizabeth Nur				timor				,		
uneral		5. Social Security Number 6. Sex	4.5	(In yrs. last birthd	y) If Under	1 Year If	Under 24 Hrs.	8. Date of Birth	Vaari	9. Birthp	place (State or Foreig	
irector		219-42-6143	<sup>M</sup> 2□F 90	Yrs	Months	Days H	lours Min.	217-Y	917	PA.	RTY)	
		Usual Residence of Decedent		40- Oit T	Landina						0d. Inside City Limit	
show d at	_	10a. State 10b. County		10c. City, Town or Ra1t.	imore						1 AYes 2 □ N	
'natural', or Items 23a or 28a-f show dical Examiner must be notified at	ecto	10e. Street and Number				0-1-		146	g. Citizen of	What Cour		
a or 2	ä	3320 Benson Ave.			10f. Zip	2122	27		USA	Wilat Oou	itry:	
ns 23 must	Funeral Director		12. Was Decedent E	ver in U.S. 1	3. Was Deced	lent of Hispa	nic Origin? (Sp	ecify Yes or No-		ace - Americ		
r Iten	Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American In Black, White, etc.  15. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  16. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  17. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  18. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, Specify Cuban, Mexican, Puerto Rican, etc.)										
Exan	b	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates: 2	42-46	1 L Yes 2	2LXINO S	pecity:		Spec	ify: W		
ed other than "natul event, the Medical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. De	cedent's Usua	l Occupation	n ng most of work	ing	16b. Kind of I	Business/In	dustry	
other than " ent, the Med	du.	Elementary/Secondary (0-12)	College (1-4or 5-	+)			strator	I .	U.S. G	overn	ment	
other than /ent, the M		17. Father's Name (First, Middle, Last)	)T	- 01	aıms a							
s marked ot umatic ever	Be	John Joseph Joyc	e			10		e (First, Middle, Maiden Surname) McCoo1				
marked matic ev	ဥ	19a. Informant's Name/Relationship (Ty)		19b. M	ailing Address	(Street and	Number or Rui	al Route Number	City or Tow	n. State. Zii	Code)	
Important: If Item 27 Is marke any injury or other traumatic once.		Winifred McCulloc			.4 Glen	coe C:	ircle,	Woodstoc	k Md	2116		
tem other		20a. Method of Disposition		20b. Place of Di	sposition (Nan crematory or o	ne of	1	Date	20c. Location	- City or T	own, State	
λ:   <del> </del>		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	New Cat			7/9/	2007 B	altimo	ro M	.d	
Important; If Ite any injury or of once.		21. Signature of Tuneral Service License					f Facility St	erling A	shton	Schwa	b Witzke	
any on o		KINI	/ Mo	1290	ofCato	nsvil	le Inc	. 1630 E	dmonds nsvil	on Av	21228	
1		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do not	enter the mod	e of dying, s	such as cardiac				Approximate Interval Between	
sician		Immediate Cause (Final disease or condition		neral Vas						1	Onset and Death	
edical		resulting in death)		a consequence of):								
miner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Coronary Artery Disease									yrs —————	
#	iner										yrs	
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cian a	Ē		Due to (or as a	a consequence or,								
physician and s the burial-transit	dical		1									
nding Ise as	Physician/Me	IF FEMALE:	3c. If yes, outcome	pf pregnancy					23d. D	ate of deliv	erv	
attending     for use as	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant at		3 ☐ Ectopic po 5 ☐ Other (sp				1	Month	Day Year	
by the a	ysi	9 Unknown	9□Unknown									
유용		Part II. Other significant conditions con	ntributing to death bu	ut not resulting in th	e underlying c	ause given i	n Part I.	23e. Did tob	acco use co	ntribute to	the cause of death?	
been signe should be	ed by							1 □ Ye	es 2□No	3 ☐ Pro	bably 4 JUnknov	
s been 2 shoul	Completed							24a. Was a	n 24t	. Were aut	opsy findings availab empletion of cause o	
page 2	E							autops perform	ned? 2∐No	death?	•	
certificate rector, pag	BeC	25. Was case referred to medical				26	6. Place of Dea	th (Check only on				
di is	To B	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatie					ome 5 Reside	ence 6 🗆 C	ther (Spec	ify)	
After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry 28b. Tim ( Year) Inju		28c. Injury at Work?		28d. Describe ho	w injury occ	urred		
ctor; A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			М		s 2□No	201	,			
Direct in by	Certification:	4 Homicide determined	28e. Place of injubulding, etc	ury - At home, farm c. (Specify)	, street, factor	, office		28f. Location (St City or Town		nber or Rui	al Route Number,	
To the Funeral Director; completely filled in by the		200 Cartifier 4 M.A. attalan Di	nielen. To the best	of my knowledge i	looth assumed	at the time	data and elec-	and due to the -	21100/0\	mannor oc	etated	
Fune tely fi	Medical	29a. Certifier 1 ☒ Certifying Phy (Check only one) 2 ☐ Medical Exami	ner: On the basis of	f examination and/o	eatn occurred or investigation	at the time, i, in my opin	uate and place ion, death occu	, and due to the c rred at the time, d	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s)	
To the Fun completely	Med	29b. Signature and title of certifier	and manner sta	· // //	296	c. License ni	umber	2	9d. Date sigi	ned (Month	, Day, Year)	
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1		30. Name and address of person who co	mploted course of d	oath /Itom 25/ Fr.	no Drine					1 100	CANALTI	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0155 am 07 07 Angela Anna Jackson 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Franklin Kosodale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Dec, 7 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** . 1918 Days Hours 1 □ M 2 🗗 F 88 Maryland 216-24-3463 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD 1 ☐ Yes 🏖 ☐ No Baltimore Middle River Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 9905 Hacker Avenue 21220 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Š Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 4th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Czyz Madeline Czyz မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson J.Jackson /husband 9905 Hacker Avenue Baltimore MD 21220 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Gardens of Faith 7/9/07 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signative of upera Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Kolit Connelly Funeral Home of Essex complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final Cerebrovasular co count **Physician** Hemisphere disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an N page certificate 1∏ Yes Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA မ this After thi funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation or Attending Division Iniury Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 強 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

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31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2:15 PM **Physician** KOBERT 02 JUL 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Anoths | Days | Hours | Min. | (Month, Day, y)

Nov 29, 1 JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☑ M 2 ☐ F Maryland 62 219-42-1935 **Director** Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1√2 Yes 2 No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or the Medical Examiner must be 21206 USA 4749 Homesdale Avenue death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 162-6 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 5-0036 "natural", or 1 ☐ Yes 2 🎇 No Specify. white ģ 62-89 3 ☐ Widowed 4 X Divorced Completed unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 College (1-4or 5+) Elementary/Secondary (0-12) maintenance 12 0 h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be Robert Andrew Keenan Sr Mildred Elizabeth Kramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau
once. Mildred Keenan/mother 4749 Homesdale Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Juneral Serve Licensee Wag 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** FAILURE /Medical Due to (or as a consequence of): Examiner CANCER SOPHAGEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ ACUTE RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural 2 Accident •• Hospital or At., hours after death. •• Director: A' 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 \* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) REJ -000 07-02-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

BRIAN DOYLE, MD

31. Date filed (Month, Day, Year)

JOHNS

KEENAN

ROBERT

4940 EASTER QUE, BALTIMORE, OID DIJJY

HOPKINS BAYVIEW.

32. Fisistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Hospital or Attending 24 hours after death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by the

23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2☐No 3☐Probably 4☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2017 who completed cause of death (Item 23a) (Type, Print) Laids 32. Registrar's Signature **ORIGINAL** 

3. Time of Death

7:30 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Germany

White

Year

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of per

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 6 2007 10:15 a <sup>™</sup> Ju1y В. Kelly Rache1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/AGood Samaritan Nursing Ctr. Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🕅 F Jan 29, 1916 Pennsylvania 146**-1**0-3265 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Directo N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 USA 2404 Lake Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Advertising Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph M. Baccellieri Rose M. Lafazia မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2404 Lake Avenue, Baltimore, Maryland 21213 Linda R. Kelly - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department or Important: If I any Injury or once, Metro Crematory Inc. 7/7/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROGEPSIS Physician /Medical Due to (or as a consequence of): Examiner FAILURG LIDNEY Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Exam attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 ☐ Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performe 1□ Yes 2 No certificate Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) iD 7300 21230 32. Segistrar's Signature 31. Date filed (Month State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 7:05 PM Edith Patricia Kennedy 1 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/AUnion Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 22 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 X F 217-14-0051 85 1922 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 40 Ridge Road 21228 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Branch Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Kennedy Edith Patricia Englehaupt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 White Oaks Avenue, Catonsville, Maryland 21228 Dale Kennedy - nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 7/6/2007 Baltimore, MD 21. Signature of Funeral Service Licensee Steven H. <sup>22</sup> Name and Address of Eacility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Oyears Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Hypertension ears Sequentially list conditions, if any, leading to him editions cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ne and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Union Memorial Huspital K amba 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 1 0 2007

State Registrar

DHMH 17 Rev 1/2001

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We	dical Exam	ner	James  4a. Facility Name	Michae (if not institution	1 King				4b. City.	Town, or L	ocation of		July 3, 20		. County of	Death	
**				norial Hospita					Baltir						Ţ	N/A	
	Funeral		5. Social Security	Number 6	. Sex	7. Age (In	yrs. las	st birthday	·	er 1 Year	If Under		8. Date of B	irth (MM/	DD/YYYY)	g. Birthi Foreign	olace (State or
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	Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.		21. Signature of F				_		22. Name and Cress 299					arvl	and.	Inc.	
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DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Terry Wayne Kline, Jr. 2007 July 821:35P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 XM 2 ☐ F 220-78-7534 9-4-1959 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Harford Belcamp 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 1421 Tarragon Ct. 21017 USA 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify:White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Wood Finisher Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Terry Wayne Kline. Janet Bartley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 9 19a. Informant's Name/Relationship (Type. Print) Father 9121 Cuckold Point Rd., Millers Island, Terry W. Kline, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 7-13-07 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityBradley-Ashton Funeral Home, PA, 2134 Willow Spring Rd., 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): enunhal ON Sequentially list conditions, if any, leading to initioalist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 ☐ 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

nesapoake Dr. Bel Lir, MD 21014

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.

**Physician** 

Examiner

**Funeral** 

Director

r 28a-f show notified at

ns 23a or ? must be r

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite

Director

Funeral

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Be Completed

/Medical

Examine Certification: To

Physician/Medical þ Completed Be

2 Accident

4 | Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

6 ☐ Could not be

determined

To the Hospital or Attending Physician 24 hours a

State

within 24

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			Please Type or Print in				_	
			For State of Maryla  1 - State Registrar		artment of F ertificate of	łealth and Mental Hy <i>Death</i>	/giene Reg. No.	1 5561.5
	Dhusisi		1. Decedent's Name (First, Middle, Last)			2. Date of D		3. Time of Death
	Physici /Medic	al	STANLEY  4a. Facility Name (If not institution, give street and number)		KLE Idh City Town o	EIN July	5 200 4c. County of Dea	
7	Examin	er		PITAL		LMORE CITY	Ac. County of Dea	A
	Funeral Director		222-36-1768 1IXM 2DF	3 Yrs.	Months Days	If Under 24 Hrs.   8. Date of Bi   Hours   Min.   2 - 10 -	nth ay, Year) 9. Bit C DE.	rthplace (State or Foreign ountry) LAWARE
	yland low at		Usual Residence of Decedent         10a. State         10b. County         10c. County	City, Town or Lo	ocation			10d. Inside City Limits
	he Mar 8a-f sh otifled	ector	DE NEW CASTLE		WILMING	GTON		1 □ Yes 2x No
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5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces? 1 Yes, Give Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒No	lispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.) Specify:		
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Maryland	d 2 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic event, <u>the Mec</u>	To Be (	17. Father's Name (First, Middle, Last) STANLEY J. KLEIN				M. (MAR	COZZI)
	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (Type. Print) MARY F. KLEIN / WIFE	260	6 W. ROI		ber, City or Town, State, WILMINGTO	
more	Pages 1 nent of H nnt: If Iter ury or oth		1 □ Burial 2 □ Cremation 3 □ Removal from State	cemetery, cre	osition (Name of ematory or other place THE: APCETT)	Date Date 7-11-07	20c. Location - City o	
Baltimore,	permit. I Departm Importai any Injui		21. Signature of Funeral Service Licensee	2		ss of FacilityCVACH /ROS	1	
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	es that igned by be deta	5	Part II. Other significant conditions contributing to death but not re	_	underlying cause giv		tobacco use contribute	
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Division or Vital	or Attending ther death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, st			(Street and Number or Fown, State)	Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my kit 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, dea nation and/or i	ath occurred at the ti	me, date and place, and due to th opinion, death occurred at the time	e cause(s) and manner a	as stated. ue to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier E. S. ANTO	NARAK	15 29c. Licens	Se number	29d. Date signed (Mod	nth, Day, Year)
	in.		30. Name and address of person who completed cause of death (Ite	em 23a) (Type			July 5	1200
	17 Sta	to	DR. E.S. ANTON ARAKIS  31. Date filed (Month, Day, Year)  32. Resistrar's Sig	nature 600	N. WOIF	e sheet b	altimoreCH	y, MD
	Registr		JUL 1 0 2007 Been	H.	book !			•
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 18:45 PM 07 2007 /Medical 4c. County of Death Examiner Hospital timore 10 If Under 1 Year | If Under 24 H 7. Age (In vrs. last birthday) 8. Date o Birthplace (State or Foreign Country) **Funeral** Year) 1 X M 2 □ F MD Director 218-40-8005 12/18/1943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at Baltimore Timonium 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12251 Roundwood Rd., #102 21093 USA by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Expense. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Alcohol & Drug Admin. Dept. Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Henry Kempske, Jr. Anna Marie Manser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jule Kempske/wife 12251 Roundwood Rd., Apt. 102, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Gardens of Faith 7/11/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License mare 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final **Physician** ardiopulmonan minute resulting in death) /Medical que to (or as a nsequence of) Examiner irator cuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2₩ No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After completely filled in by the funera Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mathiew T. Rolan M.D. 600 N. Wolfe St. Baltimore, MD

Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 109, 17, 19a per fb 869, 7-10-07 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1445 PM KEMPLER 07 1) ONALD 06 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD METTORIAL HOSPITAL HARFORD HAURE DE GRACE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 04/21/1935 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 N 1 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 72 015-28-8471 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "netural", or iteme 23s or 28s-f show the Medical Exerption must be rediffed at 1 Yes 2 □ No Director MD HARFORD **ABERDEEN** 10g. Citizen of What Country's 10e. Street and Number 10f. Zip Code USA 411 GRAYSLAKE WAY -NJ 21001 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MECHANICAL ENGINEER CARRIER CORP. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H le marked of MURRAY KEMPLER RICHMOND MURRY EVELYN ဥ 19a. I ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health ar
Important: If Item 27 le
any injury or other trau HYDEL KEMPLER / WIFE 411 GRAYSLAKE WAY - ABERDEEN, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) LAKESIDE MEMORIAL PARK 07/10/2007 MIAMI, FL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 30475 A CUTE RESPIRATORY DISTRESS STUDRAME /Medical Due to (or as a consequence of): Examiner TETACTATIC CANCER OF THE PRESTATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by GATTACINTEITINAL RUEEDING, ATMAC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown FIBRILLATION SPLENIC INFARCT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No PNEUMO MEDIASTINUM 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23s Catifior 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21338. JULY. 06,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN SWEATTAN HANFORD MEMORITE HOSPITE, HAURE de GRACO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Grandes Registrar 1 0 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 Day 30 Physician boy /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year), OG 30/200 Baltimore MD Bayview Baltimore tospital If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at TX Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 4018 Moravia Road or iteme 23a 21206 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐Yes 2X No If Yes, Give 1X Never Married 2 ☐ Married ai imore, Maryland 21215-0036 1 Tyes 2X No Specify: Specify: black þ 3 Widowed 4 Divorced "natural", Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permi. Pages 1 and 2 should be filed will Depertment of Health and Mental Hygiens importent: if Item 27 is marked other that any injury or other treumatic event, Italy Once. none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Betty M. Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4940 Eastern Avenue Baltimore, MD Bayview Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriaf 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Funeral Service 1
Ronald S Director 23a. Part 1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) prematurity Physician Extreme /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien a for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of defivery 2 Fetaf death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the linector, page 2 s 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 Fastern Ave, Baitimore, MD Shama, 31. Date filed (Month, Day, Year)-State Registrar

		-	For State Registrar	State of Maryland	•	artment of He tificate of L			giene 007	22045
			1. Decedent's Name (First, Middle, Last,					2. Date of De Month	ath Day Year	3. Time of Death
	Physici /Medic		Baby Girl L	ee B				06	30 200	7 14:35 "
ì	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of De	
			Bayview t  5. Social Security Number 6. Sec	7. Age (In yrs. Ia	of highday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		more
	Funeral Director		10	M 20 F / 1. Age (111/y)	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da O(a/3)		rthplace (State or Foreign Country)
			NONE Usual Residence of Decedent				1 0		0[200]	
	rylan show		10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	8a-1	ct	MD		Baltim					1 X Yes 2 □ No
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importants if Item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehow entry injury or other traumatic event, the Mudical Exertifical must be notified at ance.	Funeral Director	10e. Street and Number 4018 Moravia Road			10f. Zip Code	21206		10g. Citizen of What C	
	r dea	ıner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🌠 No If Yes, Give	1	1 ☐ Yes 21 No	Specify:		Specify: b	lack
21215-0036	hour	pa pa	15. Decedent's Edu	Year or Dates:	16a Deced	ient's Usual Occupa	tion		16b. Kind of Busines	s/Industry
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212	d with giene er the	Completed		none	non	e			none	
	a Hy d oth	Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nam	e (First, Middle	. Maiden Sumame)	
yla	Ment Ment arked atlc	ဥ						y M. Le		
Maryland	2 sh and 1 sm raum	ľ	19a. Informant's Name/Relationship (T)	rpe, Print)					er, City or Town, State,	
	1 end Health em 27 ther t	-	Bayview Hospital  20a Method of Disposition	20b PI	4940	Eastern Sition (Name of	Avenue E	altimor	e, MD 212 20c. Location - City of	24 or Town State
JOL	or of		1 Burial 2 Cremation 3 F	Removal from State	metery, cren	natory or other place			200. Education Only 6	, rown, state
Baltimore,	artmer ortant njury		4 Donation 5 Other (Specify)		22	. Name and Addres	s of Facility			
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п			23a. Part 1 Enter the disease or compl shock, or heart failure. List only o	ications that caused the death					rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		TOVO	maturi	7			Onset and Death
F	/Medical	7	resulting in death)	Due to (or as a consequ		ryial at	19	<u> </u>		
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	p ii	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					
	end end I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):					
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687	tificate ng phys as the	edical		d						
Вох	death certif e ettending od for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnat		Ectopic pregnancy			23d. Date of d	
.00	deat of for	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 No	4☐Pregnant at time of de		Other (specify)			Month	Day Year
P.O.	at the	Phy	9 Unknown		to the state of			na- Did		to the course of death?
Division of Vital Records,	e law requires that the death cer has been signed by the ettendir je 2 should be detached for use		Part II. Other significant conditions co	ninbuting to death but not resu	iting in the ur	nderlying cause give	en in Part I.	1 🗆	tobacco use contribute Yes 2.0 No 3.□	Probably 4 Unknown
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Ä		ШО						auto perfe	orm\ed?   death'	es 2 No
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7 <	Physiclan: this certificant all director,	유	1 ☐ Yes 2 No		ER/Outpatien		4 🗆 Nursing no		idence 6 Other (Sp	pecify)
n C	ling F	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Ďatě of Injury (Month, Day Year)	28b. Time of Injury	Work	rat t? Yes 2 □ No	28d. Describe	how injury occurred	
isi	il or Attending after death. 'Director: After d in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str		163 20110	28f. Location (	Street and Number or	Rural Route Number.
<u>≥</u>	rs after at Dire	Certification;	4  Homicide determined	building, etc. (Specify				City or To	wn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	ledical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the To the comp	×	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	nth, Day, Year)
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			30. Name and address of person who comes and some some some some some some some some		23a) (Type. tern	Ave. B	altimo	ro. A	1) 21224	L
7	Sta		31. Date filed (Month, Day, Year)	32 legistrar's Signa	ure —	and i	7.10			
	Regist	ar	JUL 1 0 20	L Carrette I	1	100				

DHMH 17 Rev 1/2001

Registrar

SOL LEVINSON & BROS., INC. MD 21208 PIKESVILLE, Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 7601 KHOSROW TABASSI M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) ORIGINAL

3. Time of Death

04:34PM

9. Birthplace (State or Foreign

MD

10d. Inside City Limits

1 ☐ Yes 2 No

COHEN

2007

Baltimore

WHITE

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2001 Baby Boy McCready /Medical 4a. Façility Name (If not institution, give street and number) 4c. County of Death or Location of Death Examiner If Under 24 Hrs. **Funeral** Social Security Number 8. Date of Bigh (Month, Day, Birthplace (State or Foreign Country) Months 1 X M 2 □ F 1<sup>Mir</sup> Year! Director June 28. 2007 Maryland none Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1√TYes 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 McLeer Street 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: black þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Raenel McCready 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21287 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Funeral Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 21201 <del>Ba</del>ltimore, MD pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. art1. Enter the dise e, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HOURS REMATURITY /Medical Due to (or as a consequence of) Examiner DISSEMINATED INTRAVASCULAR 31 Hours Sequentially list conditions Be Completed by Physician/Medical Exami physician and stree burial-trans signed by the a

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. SEPSIS  Due to (or as a consequence of):				31 40062
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		opic pregnancy ner (specify)		23d. Date of de Month	livery Day Year
Part II. Other significant condition  RESPIRATORY	s contributing to death but not resulting in the under	lying cause given in Part I. 、	1 24a. Wa	s an 24b. Were a prior to death?	robably 4 Unknown utopsy findings available completion of cause of
	1		1□ Yes	2 No 1 □ Yes	s 2 <b>X</b> No
25. Was case referred to medical examiner?		26. Place of Dea		<u> </u>	
1 ☐ Yes 2 № No	Hospital: 1 Inpatient 2 ER/Outpatient	B□ DOA Other: 4□ Nursing H	ome 5□Res	sidence 6 Other (Spe	ecify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigat		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe	e how injury occurred	
3 Suicide 6 Could not 4 Homicide determine		factory, office		(Street and Number or Rown, State)	ural Route Number,
29a. Certifier (Check only one)  12 Certifying 2 Medical Ex	Physician: To the best of my knowledge, death oc caminer: On the basis of examination and/or invest and manner stated.	curred at the time, date and place igation, in my opinion, death occu	, and due to the irred at the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)

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JUNE 29, 2007

BALTINDRE, MARYLAND

Registrar

State

within 24 hours af

To the Funeral D

completely filled i

Certification: To

Medical

WOLFE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

601 N.

32/Registrar's Signature

JULIA TRINTIS, DO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** ose 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Joseph Ritchie Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) unk 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F El Salvador unk Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at MD Catonsville 1 ☐ Yes 2X No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or r must be r 219B Suter Road 21228 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status th and Mental Hygiene. 7 is marked other than "natural", or iten traumatic event, the Medical Examine<u>r</u> 1 ∐ Yes 2**X** If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2**X** No Baltimore, Maryland 21215-0036 YYes 2□ No Specify: ģ 3 Widowed 4 Divorced White El Salvadoran Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk Cashier Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Moreira, Daughter-In law 219B Suter Road, Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Qther (Specify) \_ Oaklawn Cemetery 07/07/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas J. Skarda Funeral Home 2829 Hudson Street, Baltimore, MD 21224 23a. Parf1. Enter the vease, or complications that caused the death. Do not enter shock, or heart feilure. List only one cause on each line. The mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consi quence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine been signed by the attending physician and should be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 10 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death filled in by the 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 0 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature 29c. License number and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 300 Armon

31. Date filed (Month, Day

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Donald 2. Date of Death 3. Time of Death Pau1 Martin, Sr. **Physician** July 6, 2007 9:28 AM M Paul Martin, \*/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square Hospital Center Rosedale Baltimore Birthplace (State or Foreign Country) 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. Sept 4,1931 Maryland Director 217-24-8513 75 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 3a or 28a-f show t be notified at 10a. State 1 ☐ Yes 2 No **Funeral Director** Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21221 U.S.A. ral", or items 23a Examiner must b 1900 Grove Manor Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Maintenance 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Colley Stephen Martin 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1900 Grove Manor Drive, Essex, Maryland 21221 Mary P. Martin (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 7. 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Important; If it any injury or o once, Baltimore, Maryland 2007 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc 22. Name and Address of Facility Bruzdzinski FUneral Home, P. A. 21. Si nature if Funeral Service Ligense 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Ventricula **Physician** /Medical Due to (or as a consequence of): Examiner Coronary Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Dav Year in the past 12 months? 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 011051J 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Injury 5 Pending investigation within 24 hours after death.

To the Funeral Director; After completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE, Baltimore, MD. 1124 31. Date filed (Month, Day, Year) MACE 32. Registrar's Signature State

Registrar

LEGIES.

		•	1 - For State Registrar	State of Marylar		artment of Hertificate of L			ne 007	22052
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Nancy Meusel					July	5, 2007	1755PM
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or			4c. County of Deat	h
			5927 Ebenezer R		la at histhelass)	Whit If Under 1 Year	e Marsh	8. Date of Birth	Baltim	ore hplace (State or Foreign
	Funeral Director		5. Sociaf Security Number 6. Sex 1	7. Age ( <i>In yr</i> s.	Yrs.	Months Days	Hours Min.	Oct. 22,	e <i>ar) C</i> o	untry) Maryland
		1	Usuaf Residence of Decedent	12				UCL. 22,	1934	nai y i and
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. fnside City Limits
	B Ma	cto	Maryland Balti	more		White Mar	sh			1 ☐ Yes 2√TXNo
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	•
	eth w	ra	5927 Ebenezer Roa				1162		U. S. A	
	er de Items	nue		12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	by F	1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 2🌠 No	Specify:		Specify: W	hite
21215-0036	within 72 hours after deeth with the Maryland ene. Itan "natural" or Itema 23a or 28a-f ehow ha Medical Examiner mast be notified at	Completed by Funeral	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ition	16	b. Kind of Business/	Industry
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2	ad wit	Ю	8	,		Homemaker	<u>.</u>		Own Ho	me
מ	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	iden Surname)	
yla	Men Men Merke Marke	မှ	Herman Meusel					Meyers		
Maryland	2 sh and 1 sm raum	1	19a. Informant's Name/Relationship (Ty			•			City or Town, State, 2	
e,	s 1 and 2 and 2 and 4 and 1 an		Oscar Meyers (Cou						yland 212 c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Deportment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. The moreont: If Item 27 is marked at the than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examination and page.		1 MBurial 2 ☐ Cremation 3 ☐ P	emovariiom State		sition (Name of natory or other place	1	-		
뜵	it. Partment ortant njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Seprice, Linense			Cemetery Name and Address			altimore, uneral Ho	
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			23a. Part1. Enter the disease, or compli	cations that caused the dea						Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Finaf	. 1	1	Cardiou	lace las	Diece	200	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec		Calcion	as cuito i	D. Den	36	
	Examiner			)						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
	acuter and trans	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last							
8760,	ate be executed hysicien and the burial-transit	Ě	resulting in death) cast	Due to (or as a consec	quence of):					
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Box 6	es that the death certific igned by the ettending p be detached for use as	/Me	IF FEMALE:	3c. If yes, outcome of pregn	ancv				23d. Date of de	iven
å	eath etten for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	afdeath 3	Ectopic pregnancy Other (specify)			Month	Day Year
<u>Р</u> О	the d y the sched	ysi	1 □ Yes 21V No 9 □ Unknown	9□ Unknown						
π. σ	s that ned b e deta	by PI	Part II. Dther significant conditions cor	ntributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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ita	artifice ctor, I	Bec	25. Was case referred to medical examiner?				26. Pface of Death			
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Ē	ing P	ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	28b. Time o Injury	Work		28d. Describe how	injury occurred	
sio	tend leath tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	and to retire (Chr.	-1	Control Number
Division of Vital Records,	or At after of Direction by	Certification:	4 Homicide determined	28e. Pface of Injury - At h building, etc. (Speci	iome, tarm, sti	eet, factory, office	,	City or Town,	et and Number or Ri State)	urar Houte Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the eltending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1☐ Certifying Phy	sician: To the best of my kn	owledge, deat	h occurred at the tim	ne, date and place	and due to the cau	se(s) and manner as	s stated.
	P Ho	Medical	(Check only 2 Medical Exami	ner: On the basis of examinand manner stated.	ation and/or in	vestigation, in my op	oinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. License	number	290	I. Date signed (Moni	h, Day, Year)
)	_		I bilethettle MW)	Deputy		018	667		Tu/46.	2007
	6		30. Name and address of person who co	empleted cause of death (fit	m 23a) (Type.	Print)	, 11	11. 1	7,60	5
	3		Philip Militelly	Règistrar's Sign		7.11 C1.	Ly there,	ie 11/1	2107-	ے
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 1 0 200		1. Lox	well)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ants /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** Genesis Health Care timore Kandallstown Date of Birth (Month, Day, Year) If Under 1 Year (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 249-52-3243 1 X M 2 □ F Yrs. Director 2-22-1936 S.C Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 23s or 28a-f show Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, ith. Medi-sal Examiner must be notified at 1 X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 3112 Sumter Avenue 21215 US Α Funeral . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black \$ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Company College (1-4or 5+) Elementary/Secondary (0-12) Cement Finisher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry McCants ٥ Mamie Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Valeria Y. Jones - Daughter 2217 Lawnwood Circle Balto, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7-9-2007 Randallstown, MD 22. Name and Address of Facility March F/H 21. Signature of Funeral Service License West Wabash Avenue Balto, MD 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comples shock, or heart failure. List only one cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) attending physician Physician/Medical the use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 21 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 No 1 | Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 28c. Injury at Work? 27. Manne of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place, and due to the cause(s) and place are stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice

> State Registrar

(Check only

31. Date filed (Mont

nd title of certific

29b. Signature

Registrar's

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	aryland		artment of H rtificate of L			giene Reg. No.	17	2205;
			Decedent's Name (First, Middle, I	.ast)					2. Date of Dea Month	ath Day	Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Death		4c. County	of Death	
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36g	Director		199-20-6542 Usual Residence of Decedent		80				July 16	, 1920	Per	nnsylvania
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deat	ms Z	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span. Mexican, Puero	pecify Yes or No-	14. Race	e - Americ k, White,	can Indian, etc.
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<b>Baltimore,</b> permit. Pages 1 ar	ortant njury		4 □ Donation 5 □ Other (Special Signatur Funeral Service Lie		_  Cem	netery	2. Name and Addre			Potomac Pumphre	y Fur	ryland neral Home/
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X 6	iding ise as	/We	IF FEMALE:	23c. If yes, outcome	pf pregna	ancy				23d. Da	te of deliv	/erv
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<b>υ</b> τηστ	signed by the a	by Pi	Part II. Other significant condition	s contributing to death t	out not resu	ulting in the u	underlying cause giv	en in Part I.	23e. Did t	obacco use cont	ribute to t	the cause of death?
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Division or Vital Records, P.O. or Attending Physician: The law recuires that the	within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, I.	Certification:	4 Homicide determin		tc. (Specif	ome, tarm, st fy)	treet, factory, office		City or To		er or nur	ral Route Number,
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To th	withir To th	Me	29b. Signature and title of certifier	- 1			29c. Licens	se number		29d. Date signe	d (Month	, Day, Year)
			1 35E	sayyod	<b>V</b>	MIC	300	06243	5	7/8	1/ 20	001
5	D		30. Name and address of person w	ho completed cause of 44AD 97	death (Iten	n 23a) (Type	Print) Cente	Dr. Roc	Kville	, MO	20	850
	Sta Regist	ate rar	29b. Signature and title of certifier  30. Name and address of person w  5 H 4ED ELSH  31. Date filed (Month, Day, Year)  JUL 1 0	2007 Regist	rar's Signa	ature	ule					

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the Ma 28a-f	Funeral Director	MD 10e. Street and Nu	Wicon	nico				Sali	sbury					10a Citi	izen of V	What Cour	1 ☐ Yes 2√x	INO
th with	al Di	300 Lemon		Lane						, •••••	218	01				ISA	,	
er deat items	nner	11. Marital Status			. Was Dec Armed F 1 ☐ Yes	edent orces?	Ever in U.	S. 13.	Was Dece If Yes, spe	dent of H	lispanic O an, Mexica	rigin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	0-	14. Rac	e - Americ ck, White,		
urs aft al", or Examil	þ	1 ☐ Never Mari 3 🎇 Widowed			If Yes, G Year or I	ive	NO		1 ☐ Yes	2 <b>X</b> No	Specify	<i>/</i> :			Specify	whi	te	
72 ho "natur dical	Completed	(Spec	15. Deceden	it's Educa st grade d	tion completed)	)		16a. Dece	dent's Usu kind of wo DO NOT u	al Occup	ation during mo	st of work	unk	16b. K	ind of Bu	usiness/Ind	dustry	un
withir jiene.	ошо	Elementary/Seco	ondary (0-12)	unk	College	(1-4or 5	i+)	ше.	DONOIU	se reured	2)							
be filec tal Hyg d othe event,	Be	17. Father's Name Norman	, ,	,	74114								e (First, Middle			,		
and 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show fer traumatic event, the Medical Examiner must be notified at	၉	19a. Informant's N				ams		19h Maili	na Address	(Street			h Mae				Codo	
and 2 s alth an 27 is er trau		Dick Nib											cean P			218		
Pages 1 and of He		20a. Method of Dis 1 ☐ Burial 2		3 □Ren	noval from	State	20b. P	lace of Disperentery, cre	osition (Nai matory or o	ne of other plac	ce)	I	Date	20c. Lo	ocation -	City or To	wn, State	
# 문문을		4∏Donation				7		2	2. Name ar	nd Addre	ss of Faci	lity						
Depa Impo any i		21. Signature of Fi	ionald	S. WE		pir	ector		tate altim	Anat	omy I	Board 2120	.655 W 1	. Bal	ltim	ore S	treet	
			art failure. List	complica only one	tions that cause on	caused each lir	the death	Do not en	ter the mod	de of dyin			A				Approximate Interval Between Onset and Deat	n h
Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a	Due to	(or as	a consequ	- Co	ere	end	ma	_ 4	with 1.	Keta	2 fe	bes	1 eyea	
Examiner		Sequentially list co	onditions	b		(0. 40												
ted nsit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying r injury	₹	Due to	(or as	a consequ	uence of);										
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	dical			d														
eath certific attending p for use as	Physician/Medica	IF FEMALE: 23b. Was deceden	nt pregnant	230	. If yes, ou				7						23d. Da	te of delive	ery	
at the deatl by the atte tached for	sicia	in the past 12 1 ☐ Yes 2 I 9 ☐ Unknown	<b>⊠</b> No			nant at	2 □ Feta time of d		⊒Ectopic p ⊒ Other (s <sub>i</sub>		y 				Mo	onth	Day Year	
that th	F.	Part II. Other signi		ons contri	buting to d	death b	ut not resu	ulting in the u	ınderlying o	ause giv	en in Part	I.	23e. Did	tobacco u	use cont	ribute to th	ne cause of death	1?
n requires been sign should be	ed by	_Ce	rona	ery	Cer	te	ry	De	ele	20_			1	] Yes 2,	No No	3□ Prob	ably 4 ∐Unkn	own
e law re has be	Completed												24a. Wa	opsy		prior to co	psy findings avail npletion of cause	able
		25. Was case refer	rred to medica	ŧ l							OS Plas	a of Door	1□ Yes			death? 1 🗌 Yes	2 <b>⊠</b> No	
di iis	To Be	examiner? 1 ☐ Yes 2 🔀		_	spital:	Inpatie	ent 2	ER/Outpatie	nt 3 □ D0	Oth	or.		h <i>(Check only</i> ome 5⊟Res		6 <b>⊠</b> Oth	er (Specif	W) Hospie	
ding Pt	ion:	27. Manner of Deat 1	th 5 ☐ Pendir investi	ng gation	28a. Date (Mor	of Inju	ry y Yea <i>r)</i>	28b. Time of Injury	of M	28c. Injur Wor	yat k? Yes 2 [	INO.	28d. Describe	how inju	ry occuri	red		
or Attending after death. I Director: After d in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be	28e. Plac	e of inju	ury - At ho c. <i>(Specif</i> )	me, farm, st			163 2	1140				er or Rura	I Route Number,	
urs after rral Dir														own, State				
To the Hospital or within 24 hours after To the Funeral Direct completely filled in b	Medical	29a. Certifier (Check only one)	1 Certifyii 2 Medical	ng Physic Examine	ian: To the l r: On the l and mai	basis o	f examina	wledge, deat tion and/or in	th occurred rvestigation	at the tir n, in my c	me, date a opinion, de	and place, eath occur	and due to the red at the time	e cause(s e, date an	) and ma d place,	anner as s and due to	tated. the cause(s)	
To th within To th comp	Me	29b. Signature and	d title of certifie	er –	(1)	>	_	0	29	c. Licens	e number			29d. Da	te signe	d (Month,	Day, Year)	
		Treg	erio	M.	De	llo	20,	mi	7	PZ	245	05		0	7 -	04.	- 2007	
		39. Name and add								CHI	NAB	ERR)	DR.	SALI	SBU	RY, N	ND 2181	01
Star Registra		31. Date filed (Mor	nth, Day, Year)		32.	egistr	ar's Signa	ture				,						
negistra	31		JUL 1	0 200		Sel.	n d	K A	Markey S	<del>)</del>								

			For State Registrar	State of Ma	ırylan		artment of F <i>rtificate of</i> a		/lental Hy	ygie Reg.	0.00	7	22057
			1. Decedent's Name (First, Middle, Last	)					2. Date of D Month		Day '	Year	3. Time of Death
	/sicia ledic:		William Henry No	eal, Jr.					July	6,	2007		11:29 A M
	amine	er	4a. Facility Name (If not institution, give					r Location of Death			4c. County o		
			608 Lanoitan Road, 5. Social Security Number 6. Se		(In ure	last birthday,	Middle R		8. Date of B	irth	Balti		
Fune Direc		- 1		X 7. Age XM 2□F	69		Months Days	Hours Min.	09/03	719	37 :	Mary	place (State or Foreign otry) Land
land		ŀ	10a. State 10b. County		10c. City	, Town or L	ocation		<u> </u>			1	0d. Inside City Limits
Mary -f sh	ned	후	Maryland Baltimore	9	Mic	ldle R	iver						1 ☐Yes 2 XNo
h the	nou	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of WI	nat Cour	ntry?
th wit	nst bi		608 Lanoitan Road,	Apt. F			21220			U.	S.A.		
perinitions, final yeartowards to be permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	xaminer m	by Funeral	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1   Yes 2 N If Yes, Give Year or Dates:		- o	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or N Rican, etc.)	lo-	14. Race Black Specify:	White,	etc.
72 hot	lical	Completed	15. Decedent's Edu (Specify only highest grad	ication		16a. Dece	dent's Usual Occup	ation	dina	T 168	o. Kind of Bus	iness/In	dustry
ithin an "ne.	Med	agr.	Elementary/Secondary (0-12)	College (1-4or 5-	+)	l	kind of work done DO NOT use retired	d)	arig	TT	ome Bu	: 1 3	· · ·
led w lygier	f, E		12			Carpe	iter	18. Mother's Nam	o /First Middl				;T
l be find he ded out	eve	Be	17. Father's Name (First, Middle, Last) William Henry Neal	Sr				Marie Jo					
should and Me mark	matic	ို	19a. Informant's Name/Relationship (T	•		19b. Maili	ng Address (Street						Code)
ind 2 salth ar 27 is	r tran		Marie Stevens (Sis	•		1	Oberle Av				-		
of He	or other	-	20a. Method of Disposition  1	Removal from State	20b. F	lace of Disperentery, cre	osition (Name of matory or other plac		Date	200	c. Location - C	ity or To	own, State
Pages tment of tant: If it	land		4 ☐ Donation 5 ☐ Other (Specify		Wat	_	M. Ch. Ce		3/2007			·	ryland
permit Depar	any in		21 Signature of Funeral Service Licens	see	>	2	2. Name and Addre Br 1407 Old	üzdzinski Eastern A	Funer	al Es	Home, sex, M	P.A. aryl	and 21221
			shock r heart failure. List only of	lications that caused ne cause on each lin	the deatl e.	n. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory	arrest,	3		Approximate Interval Between Onset and Death
Physic		Ì	Immediate Cause (Final disease or condition resulting in death)	a. Cardiac	Arre	est							Oliset and Death
/Medi Exami		İ	resulting in death)	Due to (or as a			-						
		e.	Sequentially list conditions, if any, leading to immediate	b. Respirat			L					$\dashv$	
uted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Congesti	ve I	Teart :	Failure						
exec an an	пан-ти	Exa	resulting in death) Last	Due to (or as a				-					
ate be ex	ne pn	edical	•	<sub>d.</sub> Nephroti	c S	ndrom	e						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	ched for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 🗀 Feta	Ideath 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у			23d. Date Mon		ery Day Year
s that	e deta	by Phy	Part II. Other significant conditions co	ntributing to death bu	it not resi	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did	tobac	co use contril	oute to t	he cause of death?
equire:	a pin	q pa	Hypoalbuminemia						1 🗆	] Yes	ZONO :	∃ □ Prol	oably 4 □Unknown
law re	s suo	Completed	Anemia						24a. Wa	s an	24b. W	ere auto	ppsy findings available
The ate his	page	E	Chronic Obstructi	ve Lung Di	seas	se			per 1∐ Yes	forme	d? de	eath?	mpletion of cause of 2□ No
cian: ertific	ctor,	Be	25. Was case referred to medical examiner?					26. Place of Deat					
Physic this of	al dire	၉	1 100 2 2 2 110			· · · · · ·	nt 3 DOA Oth	4 Li Nursing H					ý)
ding	raner	ion:	27. Manner of Death  TNatural 5 □ Pending investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	Wor	rk?  Yes 2∐No	280. Describe	e now	injury occurre	a	
Atten death	oy tne	tical	3 Suicide 6 Could not be				reet, factory, office					r or Rura	al Route Number,
al or all Dire	u p	Certification:	4 ☐ Homicide determined	building, etc	. (Specif	y)			City or T	own, S	State)		
e Hospit 24 hours e Funera	letery Tille	Medical	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examina	wledge, dea tion and/or i	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to th rred at the time	e caus e, date	se(s) and man e and place, a	ner as s	stated. o the cause(s)
To th	сош	Me	29b. Signature and title of certifier	^ _			29c. Licens			29d.	. Date signed	(Month,	Day, Year)
ı			1 noon	en		MD	D0047	157		Jυ	uly 6,	200	7
att		Ì	30. Name and address of person who o										
07			Dr. Yoon Kim, 911				Suite 1	08, Balto	., Md.	21.	237		
Re	Stat gistra		31. Date filed (Month, Day, Year)	32. Registra	u s signa	,	,						
DHMH 17 Re			JUL_I ()	2007	Life Street	J.	porte						
							7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Cordelia Nesmith 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Social Security Number Ha Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 248-68-4928
Usual Residence of Decedent 04/04/1940 South Carolina permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Funeral Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 528 North Stricker Street 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Black, White, etc. American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Housekeeper</u> Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို Oliver Nesmith Daisy Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 19a. Informant's Name/Relationship (Type. Print) 528 North Stricker Street, Baltimore, Maryland Everline N. Taft / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □Cremation 3 □Removal from State 4 Donation 5 ☐ Other (Specify) Zion Cemetery 07/11/2007 Landsdowne, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. Signature of Funeral Service scensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Intracranial Dequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): der. To the Hospital or Attending Physician; The law requires that the death certificate be executed ereDrovasi Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? es 2 No 1□ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day 27. Manner of Death 1 □ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monga m.D

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 0 2007

**ORIGINAL** 

32. Registrar's Signature

		For State Registrar	tate of Maryland /	Department of F Certificate of		, ,	ene p. No. ) (1 1 1 7 7	771150
Physic		Decedent's Name (First, Middle, Last)  Loc	is J. Novotny			2. Date of Death Month	Day Year <b>5. 2007</b>	3. Time of Death 6:40AM M
/Med Exami		4a. Facility Name (If not institution, give street		4b. City, Town, c	r Location of Death		4c. County of Deat	
Funeral Director		211 Russe11 A 5. Social Security Number 6. Sex 1	7. Age (In yrs. last i		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y August 26,	'ear) 9. Birti	gomery hplace (State or Foreign untry)  Illinois
with the Maryland a or 28a-f show	ctor	Usual Residence of Decedent		wn or Location	ithersbur	g		10d. Inside City Limits 1   Yes 2  No
with the	Director	10e. Street and Number		10f. Zip Code		10g	g. Citizen of What Co	untry?
ter death items 23 iner mus	y Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	13. Was Decedent of H If Yes, specify Cub	20877 dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, White	
T = 1 0	Completed by	3 <b>∆</b> Widowed 4 □ Divorced  15. Decedent's Education (Specify only highest grade co	Year or Dates:	Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation	king	6b. Kind of Business/	White Industry
				Advocate for				ılting
e d ala	o Be	17. Father's Name (First, Middle, Last)	Doul Dohomto		18. Mother's Nam	ne (First, Middle, Ma	,	
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	ဥ	19a. Informant's Name/Relationship (Type.	Paul Roberts Print) 19	9b. Mailing Address (Street	and Number or Ru		<b>ae Whitake</b> City or Town, State, 2	
other		Mary K. McIntire/ 20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Remode 4 □ Donation 5 □ Other (Specify)	oval from State 20b. Place ceme	15 Highview of Disposition (Name of tery, crematory or other pla Montgomery matorium Inc	ce) Ju	Date 20	Oc. Location - City or	Town, State
Baltimo permit. Page Department of Important: If any Injury or		21. Signature of Mineral Service Licensee	/ A M00335	22. Name and Addre Rockvill Rockvill	e, Inc. e, Maryla	2007 Pert A. Pr 300 West 1 and 20850-	umphrey Fu Montgomery -2805	Maryland ineral Home Avenue
Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. Est-enly one commediate Cause (Final disease or condition resulting in death)	ons that caused the death. D ause on each line.  Colon Cancer	o not enter the mode of dyi	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death 3 Years
death certificate be executed to extending physician and dor use as the burial-transit unit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jis-asa or figury that initiated events resulting in death) Last  d	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence)	e of):				
Geath certifications of for use as	Physician/Med	in the past 12 months?	If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown		у		23d. Date of del Month	ivery Day Year
<u> </u>	Ď	Part II. Other significant conditions contrib	uting to death but not resulting	in the underlying cause given	ven in Part I.			o the cause of death?
The The page	Completed					24a. Was an autopsy performe 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
Or Vita Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	oital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DOA Oti	or.	th (Check only one)	ce 6 □Other (Spe	oifu)
Ing Ing	ation: T	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		o. Time of lnjury 28c. Inju		28d. Describe how		olly)
Divalent or after or	Certification:	4 Homicide determined	28e. Place of injury - At home, building, etc. (Specify)			City or Town,		
To the Hospital within 24 hours a To the Funeral i completely filled	ledical	29a. Certifier 1 ⚠ Certifying Physicia (Check only one) 2 ☐ Medical Examiner:	an: To the best of my knowled On the basis of examination and manner stated.	ige, death occurred at the t and/or investigation, in my	me, date and place opinion, death occu	, and due to the cau irred at the time, dat	use(s) and manner as te and place, and due	s stated. e to the cause(s)
To th withir comp	Me	29b. Signature and tile of certifier	and Da	29c. Licens			d. Date signed (Mont	h, Day, Year)
15		30. Name and address of person who complete Paul Thambi, M.D.	· · ·	, , , , ,	#300 Pool		onuland 20	1850
St Regis	ate rar	Paul Thambi, M.D. 9 31. Date filed (Month, Day, Year)	32 Registrar's Signature		" JOU ROCK	ATTIE, M	aryand Zu	VCOI

		Please Type or Print	in Black Ind	lelible Ink.	Ensure Al	I Copies /	Are Leç	jible.	
		State of Mary		rtment of H					
	4	Registrar  1. Decedent's Name (First, Middle, Last)	Cert	- L	Jeani	2. Date of Deat	eg. No.	HJ/	3. Time of Death
Physicia	_	E11e	n Rosal:	ie Owe	ns	Month 7	Day 5	Year 2007	5-44 AM
/Medic Examin		4a. Facility Name (If not institution, give street and number)	n Rosar	4b. City, Town, or				ty of Death	
LAGIIIII	G1	Haven Nursing Home		Baltimor	e		N/A	A	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🛣 F 7. Age (I	n yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1-25-1	Year)	9. Birthp Cour	place (State or Foreign ntry)  MD
(A) A   A		Usual Residence of Decedent	04			1 23 1	. , , , ,		
nyland <b>how</b> Lat		10a. State 10b. County 10	0c. City, Town or Loc	ation				1	10d. Inside City Limits 1X Yes 2 □ No
e Ma Ba-f s	Director		Baltimore	Т					
vith th		10e. Street and Number		10f. Zip Code		1	0g. Citizen o	S A	ntry?
eath v	Funeral	4504 Garrison Blvd  11. Marital Status 12. Was Decedent Eve	erinUS 13 W	21215 Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		ace - Americ	can Indian,
fter d r item iner i	Fu	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	If	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		lack, White,	
urs a al", o Exam	Ď	3 M Widowed 4 □ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Spec	cify: Bla	ick
72 hc 'natui dical	eted	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupa kind of work done o	luring most of work		16b. Kind of	Business/In	dustry
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 1 year	IIIe. D	Nurse retired,	,		St.A	gnes H	lospital
filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, I	Maiden Surn	ame)	
uld be Menta Irked	일	Charles Jackson			Martha E	. Simms			
2 sho 2 sho i and is ma rauma		19a. Informant's Name/Relationship (Type. Print)		g Address (Street a					p Code)
1 and Health		Sandra Russell-Niece  20a, Method of Disposition	20b. Place of Dispos	Garrisor	1	altimore Date	20c. Locatio		own, State
ages nt of it: If ite / or o		1 ☐ Burial 2 XX remation 3 ☐ Removal from State	cemetery, crem Metro Cr	natory or other plac	e) 7/7/:	i i	Caton		
nit. Partme artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Euneral Pervice Licensee		. Name and Addres	ss of Facility M	arch F/H			, 110
perr Dep Imp any		Timette K. Jme	2	4	300 Waba	sh Avenu	e Bal	to, MI	21215
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	1		,			Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	sclero	tic Ca	rdibuas Polon	ocilor i	dise	Pasc	_
Examiner		Due to (or as a co	consequence of):	P	20 /00	with	me	to	
as Wh	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	of	0 (01)	(01/1)	10)	-1-3-	
ecuted and I-transit	xaminer	that initiated events .							
be exectan a	Ш	resulting in death) Last Due to (or as a c	consequence of):						
eath certificate be ey attending physician for use as the buria	dic	d							
n certif	n/Me	IF FEMALE: 23c. If yes, outcome pf		lc			23d.	Date of deliv	very
death	Physician/Medical	in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown		Ectopic pregnancy Other <i>(specify)</i>				Month	Day Year
at the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but i	not resulting in the ur	nderlying cause give	en in Part I	23e Did to	hacco use c	ontribute to	the cause of death?
ires the signer	lby	Cold Cocebrollos co		coident		1 □ Y			bably 4 □Unknown
n requ	Completed by					24a. Was a	ın 24	b. Were aut	opsy findings available
he lar e has age 2	dmc					autops perfor 1∐ Yes	med? 2 <b>X</b> No	prior to co death? 1 ☐ Yes	ompletion of cause of
an: 7 tificat tor, pa	Be Co	25. Was case referred to medical			26. Place of Deat			1 1 1 6 3	2,4,110
nysici nis cel direc	To B	examiner? 1 ☐ Yes 2 No Hospitał: 1 ☐ Inpatient	2 ☐ ER/Outpatien	t 3 DOA Oth	er: 4 🕱 Nursing H	ome 5□ Resid	ence 6 🗆	Other (Spec	ify)
ing Pl	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Wor		28d. Describe h	ow injury oc	curred	
ttend death. ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury	- At home, farm, stre		Yes 2□No	28f. Location (S	treet and Nu	mber or Rui	ral Route Number,
al or A after Il Dire	Certification:	4 Homicide determined building, etc. (	(Specify)			City or Tow	n, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Medical C	29a. Certifier  1	xamination and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, or	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date sig	ned (Month	, Day, Year)
(		I Amoton a Maga	en mo	D	1550	3 7	Juli	16	2007
4		30. Name and address of person who completed cause of dea	th (Item 23a) (Type,	Print)	olphin	ST	Balt	OM	Dalal7
Sta	ite	31. Date filed (Month, Day, Year) 2007 32. Registrar	s Signature	9-10-					
Registr		JUL I U 2001 Marie	JJ. F.	DE VILLE					

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat n 24 hours after death.

The Funeral Director: A sletch filled in by the files.

Medical

29a. Certifier

31. Date filed (Month, Day, Year) 32. Registçar's Signature State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

MIN

ORIGINAL

6701 N

and manner stated.

LAMURS, VM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

58303

29d. Date signed (Month, Day, Year)

harles (+ POWSON MD Z(104

			1 - For State Registrar	State of Marylar	,			lealth ai Death	nd Me		giene Reg. No.		2201	52
ŢŽ.	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Kathryne	Prew	itt					Date of Dea Month	ath Day	Year 7	3. Time of (	
4	Examir Funeral		4a. Facility Name (If not institution, give stands 9511 Nottingham Dr. 5. Social Security Number 6. Sex	ive	last birthday)	Upp ff Unde	er Ma	Location of arlbore	0	. Date of Birt (Month, Da	Pri	9. Birth	eorge's	Foreign
*	Director			M 2 T 76	Yrs.	Months	Days	Hours	Min. F	eb 10	y, Year) , 1931	Col	ertown,	Tenn
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinat must be pullised at Once.	Director	Maryland Prince Geo  10e. Street and Number  9511 Nottin	•	per Marlboro  10f. Zip Code 20772				10g. Citizen of What of United Sta			,		
336	urs after death a	by Funeral		2. Was Decedent Ever in L Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:		Was Dece If Yes, spo 1  Yes	edent of H ecify Cuba		in? (Specif Puerto Ric	fy Yes or No can, etc.)	- 14.	Race - Ame Black, White	ican Indian,	
Maryland 21215-0036	d within 72 hou giene. or than "natura the Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed)  College (1-4or 5+)	16a. Dece (Give life. Lega	kind of w DO NOT	ork done use retired	during most ( d)	of working		16b. Kind	of Business/l	ndustry	
/land	uld be filed Mental Hyg arked otheratic avant,	To Be C	17. Father's Name (First, Middle, Last) Mack Bernice	Jewell, Sr.					1	First, Middle, Jacobs		ımame)		
, Mar	and 2 sho ealth and I n 27 Is me		19a. Informant's Name/Relationship (Typ Vicki Hock (Daught	ter)	951	1 No	tting		rive,	Upper	Mar1		MD 2077	72
Baltimore,	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo cemetery, cree ones Hi	natory`or 11 C	other place emete	ery Ju		2, 20	)7 Wa		n, Tenr	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	M01391	A	1exa	ndria	Ferr	y Roa	d, Cli	inton,		633 01d	
8760,77	Physician physician and physician and physician and physician and the physician and the physician physicia	dicai Examiner	23a. Parff. Enter the disease, or compfice shock, or heart failure. List only one finded the cause (Final disease or condition resulting in death)  S. quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.  A CUTE  Due to (or as a conse	Myo Conquence of):		,						Approximate Interval Betwo	veen leath
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 TR No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic   Other (s	oregnancy specify)	1			230	d. Date of defi Month		'ear
cords, P.	w requires that been signed by should be deta		Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	nderlying	cause giv	en in Part I.		23e. Did t	Yes 2	No 3∏Pr	the cause of debably 4 Dutopsy findings a	nknown
tal Re	n: The lav ificate has or, page 2	e Completed	25. Was case referred to medical	<del> </del>				OC Place	-10	autop perfo 1 🗌 Yes	osy rmed? 2000No	prior to death?	2 0	iuse of
Division of Vital Record	To the Mospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	To B	examiner?	ospital: 1  Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injur Wor	er: 4 🗌 Nurs	sing Home	Check only on the control of the con	dence 6 [	Other (Spec	cify)	
Divis	ital or Attan rs after deat el Director: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, sti	reet, facto	ry, office		28	f. Location (. City or To		Number or Ru	ral Route Numi	ber,
	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by	ledical	(Check only 2 Medical Examin	ician: To the best of my kn ter: On the basis of examin and manner stated.	iowledge, deat ation and/or in	vestigatio	n, in my a	pinion, death	f place, and h occurred	d due to the at the time,	date and p	lace, and due	to the cause(s)	)
)	With To T	Σ	29b. Signature and the of certifier	en m				e number 2_8_2_	.81			signed (Monti	200 [	7
	4		• • • • • • • • • • • • • • • • • • • •	NJERS,		Print)	CAI	MA	By R	20), 0	UN	, אסד	mg 2	0735
	Sta Regista		31. Date filed (Month, Day, Year)	32 Hegistrar's Sign	nature A	and a	9							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Pink Peters 16 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Doctors Hospital Lanham If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 X F Days 76 404-38-0128 June 24, 1931 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XXYes 2 □ No College Park Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9014 Rhode Island Avenue 20740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 X If Yes, Give Year or Dates: 2⊠No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Government 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Neal Elliott Cara Chipman

Physician /Medical Examiner

burial-tran

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attending pl

signed t

page 2 s certificate

director.

filled in by

After this

after death

To the Hospital within 24 hours a To the Funeral C

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify)

21. Signat re f Funeral Service Livensee

Douglas L. Peters /son

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ventriculor Due to (or as a consequence of): Conditionyopot cerebrovosculor Due to (or as a consequence of):

M00773

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hypn ton sion

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death

3 □Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

20c. Location - City or Town, State

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

a I Inknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Mknown

24a. Was an

1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25.	Was case in examiner?	referred	to medical
	1 ☐ Yes	2 No	
27	Monney of I	Dooth	

5 Pending investigation

1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 6 Could not be

2 R/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 🗆 No

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

W. Arundel Crematory July 10, 07 Odenton, Maryland

22. Name and Address of Facility
Donaldson Funeral Home, P.A.

2806 Glasgow Way, Chesapeake Beach, Maryland 20732

313 Talbott Ave. Laurel, Maryland 20707-4389

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

200/

29c. License number MOD63157 29d. Date signed (Month, Day, Year)

State

Pate 31. Date filed (Month, Day,

rd. Suite 302

Registrar DHMH 17 Rev 1/2001

			For State Registrar		State of	Maryla	-	artmer <i>rtifica</i> :			Mental H		1 1 1	7	22064
			Decedent's Name (Fit	st, Middle, Last	)			inou			2. Date of I			V 1	3. Time of Death
	Physic /Medi		Frances	E1:	izabeth		Pear1				June		e 2	2007	4:50 PM
	Exami		4a. Facility Name (If not	institution, give	street and num	- 1 -	(	4b. City	Town, or	Location of Dea			lc. County		
	Funeral		5. Social Security Number			7. Age (In yrs	s. last birthday)	If Unde Months	r 1 Year Days	If Under 24 Hr Hours Mir		Birth Day Yea			lace (State or Foreign
	Director		216-36-1894 Usual Residence of Dec	4	M 2 🛣	67	Yrs.	Montais	Days	TIOUIS WIII			939		land
	land ow			. County		10c. C	ity, Town or Lo	ocation						11	0d. Inside City Limits
	Many	ģ	Maryland N	/A		В	altimo	re							1 ☑ Yes 2 ☐ No
	ith the Marylan or 28a-f ahow	Director	10e. Street and Number					10f. Zij	p Code		· · · · · · · · · · · · · · · · · · ·	10g. C	Citizen of V	What Coun	try?
	ath wi		235 S Str	icker St	=				21223	3			USA		
	elter death with the Maryla or Items 23s or 28s-f shor	Funeral	11. Marital Status		12. Was Dece Armed For	ces?		Was Dece If Yes, spe	dent of His	spanic Origin? ( n, Mexican, Pue	Specify Yes or I	No-		e - America ck, White, e	
36	irs off	by F	1 Never Married 3 Widowed 4		1 ☐ Yes If Yes, Give Year or Da	9		1 🗌 Yes	2 <b>∑</b> No	Specify:			Specify	: Wh	ite
0-	72 hours eff natural', or	ted	15.	Decedent's Edu	cation		16a. Dece					16b.	Kind of Bu	usiness/Ind	lustry
216	ithin 7	Completed	Elementary/Secondary	nly highest grad (0-12)	College (1-	4or 5+)	life.	kind of wo DO NOT u	ork done d ise retired)	uring most of wo	orking				
21	be filed withing tall Hygiene. Id other then event, the M		12	10:10:10:10:10			La	abore					Fact		
Marvland 21215-0036	2 should be filed within 72 hours effer death with the Maryland and Mental Hygiene. Is marked othar than "natural", or items 23s or 28s-f show reumatic avant, the Medical Examination must be notified at	Be	17. Father's Name (First, Ernest	Middle, Last)	Krausc	h				18. Mother's Na Daisy	ame (First, Midd		en Suman liot		
<u> </u>	d 2 should th and Mer 7 is marks traumatic	မှ	19a. Informant's Name/F	Relationship (Ty			19b. Maili	na Address	s (Street a		Rural Route Nurr				Code)
	2 = 2 T		Catherine H	. Thoma	s (Dan	ohter)	1955				Baltim				
ore	of He of He roth	1	20a. Method of Disposition	on		20b.	Place of Dispo	sition (Na.	me of	1	Date			City or To	
Ĕ	Pages ment of h ant: If It		1 □ðurial 2 □ Cre 4 □ Donation 5 □		emoval from S	Lo	udon Pa	ırk C	emete	ry 7/2				ore,	
Baltimore.	permit. Pages 1 Department of Important: If Its any injury or ot		21. Signature of Funeral	Service Licens	96	-					udon Pa , Balti				
)]			23a. Part 1. Enter the dis shock, or heart faile	ease, or compli	cations that ca	used the dea	th. Do not ent	er the mod	de of dying	, such as cardia	c or respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	T. C. 7	Phy	PIM	onic								Onset and Death
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Box	eath certifi attending   for use as	cian/	23b. Was decedent preg in the past 12 mont 1 Yes 22 No	nani		ome of pregn th 2 ☐ Fet nt at time of	al death 3	Ectopic p					23d. Dat Mor	e of deliver	ry Day Year
70	The law requires that the death certificate has been signed by the attending toage 2 should be detached for use as	by Physician/Me	1 ☐ Yes 2 Ø No 9 ☐ Unknown		9☐ Unknov		geam 5	Other (sp	эөспу)						,
S, P	es that igned b	y P	Part II. Other significant	conditions con	tributing to dea	ath but not re	sulting in the u	nderlying o	ause giver	n in Part I.	23e. Did	tobacco	use contr	ibute to the	e cause of death?
Q . 5	w requires been sign should be	ed									14	Yes 2	2 🗆 No	3 🗌 Proba	ably 4 Unknown
S F Record	has be	Completed									24a. Wa	s an opsy	24b. V	Vere autop	sy findings available apletion of cause of
	: The cete h	Con									per 1 ☐ Yes	formed?	0	leath?	
Ce	Physician: The this certificete ral director, pag	Be	25. Was case referred to examiner?		ospital: 🏊						ath (Check only	one)			
5 5	Phys rthis raldi	5	1 Yes 2 No		i an in		ER/Outpatien 28b. Time of			4   Nutsing	Home 5 Res				)
, 2 6	Attending I r death. ector: After by the funer	ation		Pending investigation	28a. Date of (Month	, Day Year)	Injury	м	28c. Injury Work? 1 □ Y	es 2 🗆 No	200. 20001100	, 110 W 111,10	ury occurr	<del>0</del> 0	
Fro	r Attendi er death. rector: A by the fu	Certification; To		Could not be determined	28e. Place o	of Injury - At h	ome, farm, str	et, factory	y, office		28f. Location	(Street a	nd Numbe	er or Rural	Route Number,
Ö	ital or rs afte al Dir led in	Cer			Daliding	g, etc. ( <i>Speci</i>	·y/				City or To	own, Stat	( <del>0</del> )		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 127 (Check only 2 nee)	Certifying Phys fedical Examir	ician: To the base er: On the base and manne	is of examina	owledge, death ation and/or inv	occurred restigation	at the time , in my opi	o, date and place nion, death occ	e, and due to the urred at the time	cause(s	s) and maind place, a	nner as sta and due to	ated. the cause(s)
	To ti To ti	Z	29b. Signature and title o	f certifier				290	. License	number		29d. Da	ate signed	(Month, D	Day, Year)
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/	0		30. Name and address of	person who co	mpleted cause	of death (Ite	п 23а) (Туре,	Print)	1	- A.	1 2	^		10	. 0 ). > >(
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2007 12:30 a<sup>M</sup> July 3 and 3 Bessie Μ. Rush /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕱 F Director DEC 25 1919 Pennsylvania 220-38-0255 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe or "natural", or Items 23a 107 Idlewild Street, Apt. D USA 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3MWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK Biggs ၉ Benjamin Frantz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karolyn Jacobs - daughter 2823 Ady Road, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory, Inc. 7/6/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Steven H. Williams Name and Address of Eacility. Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy 20 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State Registrar

To the Hospital within 24 hours a To the Funeral I

Medical

29a. Certifier

one)

(Check only

29b. Signature and title of certifier

Upper (

and manner stated

32. Registrar's Signature

30. If me and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

H0062765

Therapeake Dr. Bel

		Please Type or Print State of Mar	yland / Depa	artment of H	lealth and N	•	-	
		1 - State Registrar	Cer	rtificate of	Death	Reg	. No. L U J	/ 22060
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\$ 50 cm	dical	Sadie F. Rathel				July	7, 2007	1:20 P M
Exam	niner	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Dear	
	7	8909 Reisterstown Road 5. Social Security Number 6. Sex 7. Age (	In yrs. last birthday)	If Under 1 Year	altimore If Under 24 Hrs.	8. Date of Birth		imore
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applicate on		Usual Residence of Decedent				May 15,	1924   Pe	nnsylvania
rylan how		10a. State 10b. County	0c. City, Town or Lo	cation				10d. Inside City Limits
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ter de item	Funeral	11. Marital Status  12. Was Decedent Eve Armed Forces?  1 □ Never Married 2 □ Married  1. □ Yes 2 ☑ No	er in U.S.   13. V	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
036 urs af al", or	2	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b> No	Specify:		Specify:	Thite
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation		ib. Kind of Business/	
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Marylan od 2 should be th and Mental th marked of traumatic eve		,				ŕ	City or Town, State, 2	,
ore, IVI		Judith Shortt (Daughter)  20a. Method of Disposition	20b. Place of Dispos	sition (Name of			laryland 2	
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tag	Completed					autopsy performe 1□ Yes 2₽	d? death? SNo 1 ☐ Yes	
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tral or /	Certification:	4 Homicide determined building, etc. (s	Specify)			City or Town, S	State)	
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of n and manner stated	kamination and/or inv	vestigation, in my o	pinion, death occur	red at the time, date	e and place, and due	to the cause(s)
vitti 70	2	29b. Signature and title of certifier  Mediue	ngth	29c. Licenso	5 2 74	$+0$ $\sqrt{3}$	Date signed (Month	
10		30. Name and address of person who completed cause of deat Enestine Wight, 230		ney Va	Illey Ro	sad, Th	MONIUM	MD 51083
S Regis	tate	31. Date filed (Month, Day, Year) 32. angistrar's	Signature	-				
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			For State Registrar	State of Maryland	/ Departme				iene L eg. No.	17	22063
lin.	Physici /Medio		1. Decedent's Name (First, Middle, Last) BCS51E	M. ROLE	5.			2. Date of Deat	Day	Year 2007	3. Time of Death  5. IOA M
	Examir		4a. Family Name (If not institution, give :	Mitted AN HO	BP.	13/7	Location of Deat	CE	4	ty of Death	9
	Funeral Director	,	5.65 ocial Security Number 30 6. Sex 10 Usual Residence of Decedent		Yrs. If Under	Days	If Under 24 Hrs Hours Min.	8. Date of Birth	20	9. Bij kipl	ace (State or Foreign
	e Marylande-fa-fahow	ctor	10a. State 10b. County N-A	10c. cia T	own of Location	CÉ				10	od. Inside City Limits
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9800	nours after de urai', or itam	d by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1Yes_2No If Yes, Give Year or Dates:	13. Was Dece If Yes, spe 1 \(\sum Yes\)		panic Origin? (S , Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Ra Bla Speci	ice - America ack, White, e	an Indian, nc. ACK
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itame 23a or 28a-f show mary injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade	cation completed)  College (1-44/5+)	6a. Decedent's Ust (Give kind of w life. DO NOT	ual Occupa ork done di usa etired)	tion uring many of wo.	rking	16b. Kind of B	Business/Ind	ustry
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	To the within To the complete	₩ W	29b. Signature and title of certifier	29c. License number		29d. Date signed	d (Month,	Day, Year)
	-		In 15 MD	Dc053373		July .	7 1	1007
	2011		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			/ 0	V V I
_	<b>ノド I</b>		Paul Kang 201 East University F	Parleway Bultimo	re Mar	yland,	2121	8
	Sta <sup>.</sup> Registra		31. Date filed (Month, Day, Year)  32. Fegistrar's Signature	made				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0 /Medical 4a. Facility Name (If not institution, give street and number, 4b. 4c. County of Death Examiner 9. Birthplace (State or Foreign Country) Brazil Social Security Numbe Age (In yrs. last bi **Funeral** 1 ☐ M 2 💢 F 71 931 75 218-66-8840 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1XXYes 2 □ No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Over Ridge Court, Apt. 3922 21210 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Brazilian δ Specify: Brazilian 3 ☐ Widowed 4 🏿 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Humberto Sachs Flavia daSilva ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Palms Remick Jr./Son 5603 Wood Way, Bethesda, MD 20816 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State St. Mary's Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 07/12/2007 Baltimore, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 Funeral Service Licen 21. Signature 1050 York Rd., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician year resulting in death) /Medical Duy to (or a a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical S IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 20 No 3 Probably 4 □Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No 24a. Was an page 2 s autopsy perform this certificate 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore,MD 21287 Street BNA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of De 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Mildret Lhoad S 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oakcrest Care Center Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/26/1930 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2(XF Washington DC Yrs 578-36-8595 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ms 23a or must be n 21234 USA 8810 Walther Blvd., Apt. 1330 Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Gustave Victor Edfeldt Effie Mae Farrell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd., Apt. 1330, Parkville, MD 21234 Philip Rhoads/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Dulaney Valley Cemeter 97/09/2007 Timonium, MD of Funeral Service Licens 22. Name and Address of Facility 21. Signature Y Ruck Towson Funeral Home, Inc. Towson, MD 21204 1050 York Rd., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an MICORED E. RHOADS 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limited Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 8800 Wether Blu mi 3 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State Registrar

		1 = For State Amend 20a-22, p	State of Mar erFH, G869, 7/	ryland / /12/07	/ Department of TTCertificate of	Health Death	and Mental Hy	/giene Reg. No.	17	2207
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yland now at		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Location				10	Od. Inside City Limits
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d be filk ental Hy ced oth	Be	17. Father's Name (First, Middle, Las George W. Larkin					er's Name <i>(First, Middle</i> .zabeth I. N		ne)	
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pt 1 Live birth 2 4 Pregnant at ti 9 Unknown	I. 23e. Did	23d. Date of delivery  Month Day Year  23e. Did tobacco use contribute to the cause of death?					
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To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		y - At home, (Specify)	, farm, street, factory, office		28f. Location	(Street and Numb wn, State)	er or Rural	Route Number,
Hospi 24 hour Funer etely fill	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	nysiclan: To the best of miner: On the basis of e and manner state	examination	dge, death occurred at the and/or investigation, in my	time, date a opinion, de	nd place, and due to the ath occurred at the time	e cause(s) and ma , date and place,	nner as sta and due to	ated. the cause(s)
To the vithin To the comple	Me	29b Signature and title of certifier	And mi	), M	29c. Licer	ose number	4/4	29d. Date signed	7 ~	A - 13
		30. Name and address of person who	completed cause of dea	ath (Item 23	a) (Type, Print)	net.	Part	Danda	1/ch	007 UN 21/33
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1109 LCD	2114	KUCIA,	wnuu	13/04	UI 21/33
Regist		1111 1 0 1	2007	J. H.	Sperker					
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State of Maryland / Department of Health and Mental Hygiene

1- State Amend 26, perverbal (869, 7/10/07 TT Certificate of Death

Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Loretta Marie Smith 2007 5:45 р м July 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 528 Sunset Road Baltimore n/a 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1□M 2XF Months Days Hours 218-30-8443 19, Director 1935 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 28a-f sh notified Director n/a 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 528 Sunset Road 21223 ms 23a United States Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natuury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Money Counter Vending 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward E. Bowers Elizabeth Lehr ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Benton Smith / Son 2917 Kingsley Street, Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 7/10/2007 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 💆 No Month Year Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1∐ Yes 2 **I** No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient Medical Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital 29a, Certifier KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (I)em 23a) (Type, Print) 57. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

	<b>7</b> 1
Richard Thomas Schultz	State of Maryland / Department of

ichard Thomas			ment of ficate of		ental Hy		g. No.	7 2027		
Physicia	in/	Decedent's Name (First, Middle,Last)			1	2. Date of Death Month	Day Year	3. Time of Death 7		
∕ledical Exami ∕	ner	Richard Thomas Schultz Jr.  4a. Facility Name (if not institution, give street and number)	14	. City, Town, or Locati	on of Death	July 4, 200	4c. County of Death			
		5003 Wilkens Avenue		Catonsville		•	Baltimore Cou			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)		Inder 24Hrs.	8. Date of Birt	h(MM/DD/YYYY) 9. Bir Foreig			
Director		215-11-5931   1XM 2 F 22	Yrs.	Months Days Ho	ours Min.	July 6	, 1984 <sup>co</sup>	untry) MD		
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0036 within 72 hours after death with the Maryland gene. ner than "naturul", or items 23a or 28a-f sho Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces?	13. Was	Decedent of Hispanic s, specify Cuban, Mexi	Origin? ( Spe can, Puerto F	cify Yes or No- lican, etc.)	14. Race - Amer White, etc.	can Indian, Black,		
fter des		3 Widowed 4 Divorced If Yes, Give Year	1	res 2 X No spec	cify:		Specify: T.Th	ite		
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5-0036 ed within 72 hours afte bygiene. other than "naturin!" the Medical Examine	Completed	17. Father's Name (First, Middle, Last)	Home Ir	nprovement	ther's Name (	First, Middle, M	Glass (Maiden Surname)	Company		
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2 a d a s		19a. Informant's Name/Relationship (Type, Print)			Number or Ru	ral Route Num	ber, City or Town, State	, Zip Code)		
alth alth		Richard T. Schultz, Sr. / fat	ner 32	O First Av	ze. Lar	<u>nsdowne</u> <sub>Date</sub>	MD. 2122 20c. Location - City or	7 Town, State		
Baltimore, permit. Pages I an Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State T Older	matory or other		100	-09-07	Baltimor			
Baltimo permit. Page Department of Important: injury or otd		4 Donation 5 Other Specify:		•				.e, rib		
Dep Deri		22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 7719 Hammonds Ferry Rd. Lansdowne, Ambrose Funeral Home of Lansdowne, Ambrose Funeral Hom								
Physician		23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.	o not enter the	mode of dying, such	as cardiac or	respiratory arre	est, shock, or heart	Between Onset and		
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tox 6876 eath certificate eath certificate attending phy for use as the	an/I	past 12 months?	2 Feta	l death 3 Ec	topic pregnan	су		Day Year		
	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown	n 5 Oth	er (Specify)			1			
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Vital ysician: his certif director,	a	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 E	R/Outpatient	26.Place of De		-	Residence 6 ✔ Othe	r: Scene		
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Division pital or Attendiours after death. eral Director: /	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At hom			g, etc.	28f. Location (S or Town, S	Street and Number or Ri tate) Kens Ave. Cato	ural Route Number, City		
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Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atternoonpletely filled in by the funeral director, page 2 should be detached for a	Medical	one) 2 Medical Examiner: On the basis of examination and	or investigation	on, in my opinion, deat	h occurred at	the time, date	and place, and due to the	ne cause(s)		
5 . ≥ € . S	Me	and manner stated.  29b. Signature and title of certifier		29c. License num	nber		29d. Date signed (Mo	nth, Day, Year)		
		my him, mo		O.C.M.E.			July 5, 2007			
		30. Name and address of person who completed cause of death (Item 2 Ling Li, MD Assistant Medical Examiner 111 F		, Baltimore, MD 2	21201					
St	ate	31 Date filed (Manth Day Year) 32 Registrar's Signature		,						
Regis	rar	JUL 1 0 2007 Here &	600	<u> </u>	<u>.</u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene David Julian Sahid Polanco

	1- For State Certificate of Death Reg. No.
Physician/ lical Examiner	1. Decedent's Name (First, Middle, Last)  David Julian Sahid Polanco  David Julian Sahid Polanco  David Julian Sahid  David Julian Sahid  2. Date of Death  Month  Day  Year  July 5, 2007  1048 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick  4c. County of Death Frederick
Funeral Director	5. Social Security Number N/A 1 M 2 F 19 Yrs.   19   19   19   19   19   19   19   1
Aaryland 28a-f show any 1 at once. ector	Usual Residence of Decedent  10a. State
th the Maryland 23a or 28a-f sho notified at once	0141 / 0112 / 1170
ter death with ", or items 23 remust be no	3 Mildound 4 Divorced If Yes Give Year 1 Y Yes 3 - No energy II. Specify Hespenic
AID 21219-0036 2 should be filed within 72 hours after death with the Maryland hard Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-1 she maire event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	45 December 6 Propries (Specific propries and completed) 150 December 1 Investigation (Sixo kind of work date) 150 Kind of Business/Industry
Z 1Z 19-0030  und be filed within 72  Mental Hygiene marked other than " e event, the Medical  To Be Comple!	
MD 21.	P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Carolina Jones - Cousin 79 Spiral Branch Ct Lorien, N.C. 28356
Pages 1 an tent of Hea tent of Hea tent of the tent tent of the tent tent tent tent tent tent tent	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Funeraria Gaviria S.A 7/11/2007 Bogota, Columbia
Chysician Injury of Injury	21 Signature Peral Service Licensee 22. Name and Address of Facility March F/H West  4300 Wabash Avenue Balto MD 21215  226. Part / Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interview (Approximate Interview
/Medical aminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Alcohol intoxication  Due to (or as a consequence of):
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated eventer resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):
execut an and al - tra	_
ath certif	2 So. Was decedent pregnant in the past 12 months?    1
that the degree by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of the cause of the cause of death of the cause of the cause of the cause of the cause of death of the cause of the ca
has been 2 should	24a. Was an autopsy findings avail autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
hysician: this certi	25. Was case referred to medical 26. Place of Death (Check only one)    Check only one   Check only one
Attending death.  cetor: A sy the fu	1 Natural 5 Pending Investigation Fnd 7/5/2007 FNd 10:30 am 1 Yes 2 X No unk  2 Accident Investigation Representation of the pull-diagraphy of the pull-di
Hospi 24 hou Funer stely fil	29a Certifier
To the Ho within 24 To the Fu completel	29b. Signature and title of certifier  O.C.M.E.  July 6, 2007
Cp 8	30. Name and address of person who completed cause of death (Item 23a)  David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	Los Philips Circulus

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#7. perFH. G869. 7/10/07. WS

_			1 - For State Registrar	State of	Marylar		tificate c			ental Hygi	ene g. No:	7	220	75
	Physici /Medie		1. Decedent's Name <i>(First, Middle, Last)</i> An g	gela Ca	therine	e Scard	ina			2. Date of Death Month July	Day	Year 2007	3. Time of 10:00	
	Examir		4a. Facility Name (If not institution, give s 506 Fairfax Aver		ber)		4b. City, Town, or Location of Death Baltimore				4c. County		undel	
	Funeral Director		Social Security Number		. Age (In yrs34	last birthday).	If Under 1 Ye Months Da	ar If Under	24 Hrs.	8. Date of Birth (Month, Day, June 20	Year)	9. Birthp	lace (State o	or Foreign
	h the Maryland r 28e-f show	Irector	Usual Residence of Decedent	rundel	1	y, Town or Lon Baltimo		Ð		10	g. Citizen of V			ity Limits
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-1 show any njury or other treumatic event, the Musical Exacilizational page.	by Funeral Director	506 Fairfax Aver  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	IUE  12. Was Deced Amed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? 2 📉 No	li li		uban, Mexica	n, Puerto P	cify Yes or No- lican, etc.)	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White			
21215-0036	ad within 72 ho /giene. er than "netur t, the Madical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8th		4or 5+)	(Give life. [	ent's Usual Oc kind of work do. DO NOT use ret maker	ne during mos	st of workin	g 1	6b. Kind of Bu	siness/In		
Maryland	outd be file I Mental Hy harked oth	To Be (		g Tully		· ·		G	race	(First, Middle, M Schmidt				
	and 2 sh salth and n 27 Is m		19a. Informant's Name/Relationship (Type Angela Branham /			506 F	airfax			Route Number, Baltimo				25
Baltimore,	Pages 1 lent of He nt: If iter ry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from St	ate	emetery, crem	ition (Name of atory or other p 1 Cemet	' 1	7/9/2		oc. Location - Baltimo	•		and
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service License	emer	ousi	1 22.	Name and Add	fress of Facili	ty Gon	ce Fune	ral Ser	vice	, P.A.	
	Physician /Medical		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that car e cause on eac	used the death	h. Do not ente	r the mode of o	ying, such as	cardiac or	respiratory arres	st,		Approximate Interval Better Onset and I	e ween Death
28760,	Examiner  ohysician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	r as a consequence of a consequence of as a consequence of as a consequence of as a consequence of a cons	uence of):	ailw	e a	e n	ar retasti	rses		lyed	ır
.O. Box (	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		h 2 ∏Fetal nt at time of di	death 3	Ectopic pregnal Other (specify)				23d. Date Mor	e of delive		Year
ο.	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions con	tributing to dea	th but not resi	ulting in the un	derlying cause	given in Part I		23e. Did toba	cco use contr		ne cause of d ably 4 □L	
al Records,		Completed									9d? d (No 1	/ere autorior to coreath?	psy findings and pletion of ca	available ause of
Division of Vital	ing Phys Mer this uneral di	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No He  27. Magner of Death 1 Natural 5 Pending 2  Accident investigation	ospital: 1  lnp 28a. Date of (Month,		ER/Outpatient 28b. Time of Injury	28c. In	other: 4 Nu	rsing Hom	Check only one  5 X Residen  d. Describe how	ce 6 □Othe		')	
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: 4 completely filled in by the fr	Certification:	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At ho , etc. (Specify	ome, famn, stre	et, factory, offic	9	28	If. Location (Stre City or Town,		r or Aura	l Route Num	ber,
	ie Hospi 24 hou ie Funer iletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physical Examin	ician: To the b er: On the bas and manne	is of examinat	wledge, death tion and/or inve	occurred at the estigation, in m	time, date an opinion, dea	d place, an th occurred	d due to the cau I at the time, dat	se(s) and mar e and place, a	ner as st	ated. the cause(s	)
	To th withir To th comp	Σ	29b. Signature and title of certifier  Muem	D				se number	3		J. Date signed		_	
	jo		30. Name and address of person who cor	npleted cause	of death (Item	23a) (Type, P Haru	rint)	St. B	alt	more	$m_{\mathcal{D}}$	212	25	
	Sta Registra	e	31. Date filed (Month, Day Year) 0 20	707 32. PM	istrar's Signal	ture -	rete							

# Saltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician; funeral director. After this after death. filled in by

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2007 2:20 A John A. Szczepanik, III /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Spa Creek Nursing Home Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F Yrs. Director 220-68-5133 July 27, 1956 DE Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heathh and Mental Hygiene. Instit If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 641 Walton Rd. 20639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John A. Szczepanik, Jr. Teruko Sato 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara Szczepanik/Wife 641 Walton Rd.; Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 11 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Stanislaus Cem. 2007 22. Name and Address of Facility 1 Second Ave. SW to M01411 Singleton Funeral Home, Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Iver e ancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate has been signed by the attending prector, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Aursing Home Hospital: 1 ☐ Yes 2 ☐No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? **T**☐ Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) Media and manner stated. 29b. Signature and title q 29d. Date signed (Month, Day, Year) D32036 (Item 23a) (Type, Print) 30. Name and address of person who to Drive Cherter, Mis 2/61 307 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene State Amend #18, perFH, g869, 7/17/07 TT Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Nadia Soriano Ju1y 10:05P <sup>™</sup> 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 29 Mansion Road Linthicum Anne Arunde1 8. Date of Birth (Month, Day, Year) Dec. 19, 1964 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 220-78-2145 42 Director MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Expresser must be notified as MD Anne Arundel 1 ☐ Yes 2 No Linthicum Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Mansion Road 21090 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Clerk Clerica1 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill treent of Health and Mental H. lent: If item 27 is marked out Be **Nadia** <del>Natia</del> Amelia Klimovitz Milford Lawrence Redel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Soriano/Husband 29 Mansion Road Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 9. 20c. Location - City or Town, State Department of H Importent: If ite eny injury or ot once. 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)
Signature of the a Service Licensee Chesapeake Cremation 2009 Stevensville, MD permit. 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signatu 1 Second Avenue SW Glen Burnie, MD 21061 monac Aart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate ease. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 🗌 Yes 2 🗭 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has performed? 1 ☐ Yes 2 Ø No certificate Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 5 Pending within 24 hours after death.
To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) c. mpletely filled in by 4 Homicide To the Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and little of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1100 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1206 PM 0 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Hospiceatthe Salisbur 8. Date of Birth (Month, Day Year) October 12, 1931 If Under 1 Year | If Under ocial Security Number 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 Mary Tand 212-28-9262 75 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Maryland Worcester Director Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury injury or other traumatic event, the Medical Examiner must be reany injury injur 29 Brandywine Drive 21811 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No White ş Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maryland School for the Blind Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin Samuel Shortt Marie Elizabeth Wehner ပ 19a. Informant's Name/Relationship (Type. Print) Celeste Emerson/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5649 Byard Avenue Seaford Delaware 19973 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/07 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Latera Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a. Was an certificate has autopsy performed 2 X No 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O.

Registrar

Medical

31. Date filed (Month, Day, Year)

JUL 1 0 2007

(Check only one)

29b. Signature and title of certifier

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 32. egistrar's Signature

and manner stated.

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

07-05063 Jeffrey D. Smith

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ July 2, 2007 Year 2032 hrs Medical Examiner Jeffrey Donald Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cecil Union Hospital 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min Director Country) Maryland 1 X M 2 F 8,1976 30 217-92-1857 Sept. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Virginia|Prince William Montclair Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4841 Keswick Court 22025 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc Armed Forces? death 1 X Never Married 2 Married 1 X Yes 9 Yes 2 X No specify: after Widowed Divorced f Yes, Give Yea Specify: White marked other than "natural", event, the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 MD 21215-0036 t. Pages 1 and 2 should be filed within Tment of Health and Mental Hygiene. rtant: If item 27 is marked other than 9 or other traumatic event, the Medic. Loss Prevention Agent Furniture Industry 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Darrell Smith Charlene Ronald Deidri Kellv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print ) Ronald D. Smith Belmullet Court Unit 301 Timonium. Marvland 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition Gardens of Faith Cemetery 1 X Burial 2 Cremation 3 Removal from State portant: 7-7-2007 Rossville Maryland Donation 5 Other Specify: nat f F ra S rvice Licensee 22. Name and Address of Facility Home, 21204 Ruck Towson Funeral 1050 York Road Towson, Maryland ىتە 23a. Port I, Entor the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause Between Onset and /Medical Death Immediate Cause (Final disease Narcotic intoxication (morphine) aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED 27,28a-f, perME,g869, 7/13/07 TT red by the attending physician detached for use as the burial X UNPENDED P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one Division of Vital Be Hospital: 1 Inpatient 2 Y ER/Outpatient 3 Other this DOA Nursing Home 5 Residence 6 1 V Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Yes 2 X No Director: Pending Fnd 7/2/2007 lunk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State)
Found on highway interstate 95 determined (Specify) unk Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 3, 2007 Diase e hua 30. Nam- and address of person who complete cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201 distrar's Signature State 31. Date filed (Month, Day, Year) 32. R

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Arthur P. Thomas, Sr. 2007 July 4, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2622 Tulip Avenue Baltimore Lansdowne 6. Sex 1 XM 2 ☐ F If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Yrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 214-26-9616 24, 1929 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits Baltimore 1 ☐ Yes 2 No Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2622 Tulip Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard W. Thomas Maude Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Thomas - Wife 2622 Tulip Avenue, Lansdowne, MD 21227 20b. Place of Disposition (Name of Cemetery, crematory or other place) Glen Haven Date 20a. Method of Disposition 20c. Location - City or Town, State 1M Burial 2 □ Cremation 3 □ Removal from State 4 Qonation 7-9-2007 Glen Burnie, MD 5 Other (Specify) Memorial Park 1-3-200, 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral S 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Maary arterioselero ic cardiovascular discess Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gonsequence off: Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed? 1☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician /Medical Examiner

be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Examiner burial-transit Physician/Medical Completed

attending physician for use as the buria been signed by the should be detached has

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

State Registrar

Certification:

Medical

2 Accident

3 Suicide

29a, Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier R. Galleger, Mo

6 ☐ Could not be

29c. License number D01786

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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10. Name and address of person who completed cause of death (Item 23

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

JULY 06, 2007

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32. Registrar's Signature

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 6-15 p. 2007 Anna Mabe1 Votta July 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Woodbridge Valley Nursing Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 5/26/1921 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ☑ F 86 Yrs. Director 229-22-2272 VA. Usual Residence of Decedent the Maryland 10b.County Baltimore 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or items 23e or 28e-f show treumatic event, the Medical Examinar must be notified at MD. Baltimore 1 ☐ Yes 2 MNo Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 748 West Hills Pkwy. 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "neturel", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robertson Earle Plouden Evans Sallie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Evans Votta, son 748 West Hills Pkwy., Baltimore, Md. 21229 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department Importent: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. New Cathedral Cem. 7/12/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPERTENSIVE CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Lary, loading to him ediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of). Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical the use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No by the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Munknown 1 ☐ Yes 2 ☐ No 3 Probably leted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Compl autopsy performed? this certificate 2 No 1∏ Yes 2 No 1 Yes Division of Vital director, 25. Was case referred to medical 26. Place of Deatn (Check only one) examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UMA BUSINESS REISTERSTOWN MD CENTER DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

JUL 1 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Year CLEMMIE 11:05 AM J427 04 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Secours Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🛛 F 463-30-7461 Director Texas 12-2-1922 84 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at X Yes 2 No Director MDNA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21216 Funeral 3010 Grayson Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X**☐ No Black Specify. þ 3 Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Home Visitor permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien Important: If Item 27 is marked other trainmast. 12th grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sophia Jenkins Cliff Tatum ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 Tentmill Lane Apt C Pikesville, MD 21208 William W. Wyatt III-Son 20a. Method of Disposition

f⊞Burial 2 □Cremation 3 □Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Arbutus Memorial Pk 7/9/2007 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Pa/1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, MD 21215 Approximate Interval Between Onset and Death Immediate Cause (Final discusse or condition refulting in death) **Physician** DEHYDRAT /Medical Due to (or as a consequence of): **Examiner** PANCREAT UNICHONA Sequentially list conditions, if any Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner M Hospital or Attending Physician: The law requires that the death certificate be executed ARTERIOSCLEROTIC attending physician and for use as the burial-tra-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2.00 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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2000 W.

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BALTOST. BALTOMD.

1710.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATEZ,

32 Registrar's Signature

SUDICIR.

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar		epartment of F Certificate of			iene	7 22084
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	/Medic	al	4a. Facility Name (If not institution, giv		•	4b. City. Town, o	r Location of Death	July	6, 2007 4c. County of De	12:15 a <sup>M</sup>
ě.	Examin	er	Laurel Regional H			Laurel			Prince	George's
100	Funeral Director			ex 7. Age (i	In yrs. last birth 8 Y	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 27,	<sup>Year)</sup> 1939 L	Birthplace (State or Foreign Country) aurel, MD
	land ow at		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
	a-f sh	ctor	Maryland Anne Ar	undel	Laurel					1 □ Yes 2 <b>\\</b> No
	vith the	Director	10e. Street and Number	1-		10f. Zip Code		10	0g. Citizen of What	Country?
	leath v	Funeral	3364 Wye Mills So	12. Was Decedent Eve	er in U.S.	20724		ecify Yes or No-		merican Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married <b>XX</b> Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2★ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2\(\text{CK}\)No	an, Mexican, Puèrto Specify:	Rican, etc.)	Black, W Specify:	hite, etc. White
-C	"natu "natu	letec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. D	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	ation during most of work	ing	16b. Kind of Busine	ss/Industry
717	s within giene. r than the M	Completed	Elementary/Secondary (0-12) Grade 9	College (1-4or 5+)		Foreman	<i>'</i> )		Bridge Bu	ilding
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Z	d Meni marked matic	T <sub>o</sub>	Elias Clinton Win  19a Informant's Name/Relationship (		10h	Mailing Address (Street		ll Shipl		7:- 0- 1-1
	nd 2 sl alth an 27 is r ir traur		Joann Q. Wines /	spouse		64 Wye Mil				
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		20a. Method of Disposition  **MXBurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	Removal from State		Disposition (Name of crematory or other place)			20c.Location - City Laurel, M	
Palti	permit. Departrimit importa any inju		21. Signature of Funeral Service Licer	M0077	0	22 Name and Addre Donaldsor			.A. l, Maryla	nd 20707
ř			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do no					Approximate Interval Between Onset and Death 3 -4 Days
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pneumon						3 -4 Days
	/Medical Examiner		Teading in death)	Due to (or as a c	consequence of	):				3 -4 Days
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.O. Box	the death certific y the attending p	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1□Live birth 2 [ 4□Pregnant at tin 9□Unknown	Fetal death	3□Ectopic pregnancy 5□ Other (specify) _	<u>'</u>		23d. Date of Month	delivery Day Year
cords, P	w requires that the de been signed by the should be detached	d by Phys	Part II. Other significant conditions of	contributing to death but r	not resulting in t	the underlying cause giv	en in Part I.			to the cause of death?  Probably 4XX0nknown
Heco H	The la te has	Completed		<i>:</i>		<u> </u>		24a. Was ar autops perforn 1∐ Yes 2	v prior	autopsy findings available to completion of cause of ?
NIT A	nding Physician: Th. After this certifical funeral director, possible for the control of the con	Be	25. Was case referred to medical examiner?	Hospital:		eatient 3CLDOA Oth	26. Place of Deat	h (Check only one	e)	
0	F is b	T. To	1 ☐ Yes 2 XXIo  27. Manner of Death	28a. Date of Injury	28b. Tir	me of 28c. Injur	4 LI Nursing no	ome 5 Reside	nce 6 Other (S	pecify)
VISION	anding a.h. or Afte	atior	1 XX atural 5 ☐ Pending 2 ☐ Accident investigation		<i>'ear)</i> Inj		k? Yes 2 □ No			
	s fter de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (		n, street, factory, office		City or Town	ı, State)	Rural Route Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director After to completely filled in by the funeral	edical	29a. Certifier 1 ← Certifying Ph (Check only one) 2 ☐ Medical Exam	nysician: To the best of r miner: On the basis of ex and manner stated	kamination and∂	death occurred at the tir or investigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, d	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	With Com	Σ	29b. Signature and title of certifing	P.M91	In t	29c. Licens	e number 3953	2	od. Date signed (Mo	2007
	0		30. Name and address of person who Timothy McClain,	M.D. 321 P	rince C	ype, Print) George Stre	et Laure	l, Maryl	and 2070	17
	Sta Registr		31. Date filed (Month, Day, Year)	32. Figistrar's	Signatur	Grade				

		For State	State of Ma	-	epartment of H Certificate of L			711	07	22085
		Registrar  1. Decedent's Name (First, Middle	le, Last)		Jertinoate or E	Joann	2. Date of De			3. Time of Death
Physicia /Medic			Charles Ells	sworth Wi	11iams		July	8 20	Year د2	0300 A M
Examin		4a. Facility Name (If not institution	-			Location of Death		4c. County of		1-1
		5. Social Security Number	shinton Medic 6. Sex 7. Ag	e (In yrs. last birth		Bur N	→ € ■ 8. Date of Bir	Anne		lace (State or Foreign
Funeral Director		201 12 2923	1 <b>3</b> M 2 □ F	81 Y	Months Days	Hours Min.	(Month, Da		Cour	nsylvania
pu		Usual Residence of Decedent		10c. City, Town	ar Location			_, _,_,		0d. Inside City Limits
faryla shov	ō		ne Arundel		Burnie					1 ∐Yes 2 🔼 No
the N 28a-i notifi	Director	10e. Street and Number		0201	10f. Zip Code			10g. Citizen of W	hat Cour	itry?
th with 23a or st be	al D	315 Marie Av	renue		21	060		U.S.	Α.	
r deal	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp nn, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race Black	- Americ , White,	an Indian, etc.
s afte ", or if	by Fi	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	WW II	1 ☐ Yes 2 🔼 No	Specify:		Specify:	Whi	te
be filed within 72 hours after death with the Maryland vtal Hygjene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted k	15. Deceder	nt's Education	16a. D	ecedent's Usual Occup	ation		16b. Kind of Bus	siness/Inc	dustry
thin 7; e. an "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or 5	5+)	Give kind of work done of life. DO NOT use retired	during most of wor  )	кіпд	Cabine	.+ Ca	
led wi dygien her th	Co	17. Father's Name (First, Middle,	2 years		Buyer	19 Mother's Nam	no (Eirot Middle	, Maiden Surnami		шрану
d be fi	Be c		ymond A. Wil	liams			e Daughe		3)	
and 2 should and 2 should n 27 is marke er traumatic	ᅀ	19a. Informant's Name/Relations	ship (Type. Print)	19b. I	Mailing Address (Street a	and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip	Code)
and 2 salth a		Carol George	e / Daughter		4 - 2nd Ave		G1en	Burnie,	Mary	1and 21061
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from State	20b. Place of L cemetery	Disposition (Name of crematory or other place	re)	Date	20c. Location -	•	
t. Pag rtmen rtant: rjury		4 Donation 5 Other (5		Glen H	aven Mem. P	an of Families				Maryland
permit. Departn Importa any Inju		21. Signature fruneral Strvice	Z ensee		4001 Ritch	(70	once Fur ay Balt	neral Ser Limore, M	vice laryl	, P.A. and 21225
		23a. Part   Enter the disease, o shock, or heart failure. Lis	or complications that caused tronly one cause on each li	d the death. Do no	t enter the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		monia						
Examiner		,	Due to (or as	a consequence of	,					
ALC: N	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	consequence of						
ecuted Ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		\.					
ate be executed hysician and the burial-transit		rooding in dodary East	Due to (or as	a consequence of	j:					
	edical		d							
sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy 2 D Fetal death	3 □Ectopic pregnancy	,		23d. Date		•
e deat he atts ied for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a		5 ☐ Other (specify) _			Mor	nth	Day Year
hat the	Phy	Part II. Other significant conditi	ions contributing to death b	out not resulting in t	the underlying cause give	en in Part I.	23e. Did t	tobacco use contr	ibute to t	ne cause of death?
uires t signe	d by			3	, , ,		1 🗆	Yes 2 No	3 ☐ Prob	ably 4 Unknown
w reg s beer s shou	Completed						24a. Was	an 24b. V	Vere auto	psy findings available
The la	omo						auto perfo 1□ Yes	ormed? d	rior to co leath? □Yes	mpletion of cause of 2□ No
cian: ertifica ctor, p	Be C	25. Was case referred to medica examiner?				26. Place of Dea				
Physic this o	ဥ	1 Yes 2 No	Hospital: 1 Pripation 1 28a. Date of Inju			4 La Nuising F		dence 6 Othe	_ ' '	y)
ding I h. After funer	tion:	27. Manner of Death  1 Natural 5 Pendi 2 Accident invest	(4.4		ury Wor	yat k? Yes 2∐No	28d. Describe	how injury occurre	ea	
Atten r deat ector: by the	ifica	3 Suicide 6 Could 4 Homicide deterr	not be 28e. Place of Inj	ury - At home, farr tc. (Specify)	n, street, factory, office		28f. Location ( City or To	Street and Number	er or Rura	al Route Number,
tal or rs afte al Dir	Certification:	4 I Torriolde	building, ea				City of 10	wii, State)		
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ing Physician: To the best I Examiner: On the basis of and manner st	of examination and	death occurred at the tir /or investigation, in my o	me, date and place ppinion, death occu	e, and due to the urred at the time	cause(s) and ma , date and place, a	nner as s and due t	tated. o the cause(s)
To th withir To th comp	Me	29b. Signature and title of certific			29c. Licens			29d. Date signed		
1/4X		1 Hem of	m MI)			27415		July 8	10	
[4		30. Name and address of person Henry Fran	who completed cause of c	Baltimo	ype, Print) C WASH	ntow 1	hedica,	1 CEN	res	
Sta Registr		31. Date filed (Month, Day, Year JUL 1	0 2007 32. Fiegisti	rar's Signature	ype, Print)  C WAShi					

State of Maryland / Department of Health and Mental Hygiene 🔱 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** Barbara Ann Walker Ju1y 6. 2007 7:55 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Westminster Carroll Dove House If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 7, 1956 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 □ M X XF 50 Maryland Director 213-72-3795 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes XX No Director MD Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21136 112 Butler Rd. U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 Yes XX No Baltimore, Maryland 21215-0036 "natural", or Specify: Specify: White þ XX Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Correction Officer Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Elizabeth Weis Samuel A. Wagenfer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Wilgate Rd. Owings Mills, MD 21117 April Zellmer / Sister 20a. Method of Disposition
1 ☐ Burial XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 injury o Metro Crematory Inc. 7/10/07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Singral Service Licenses 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** don disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the as attending I for use as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death Ö the 9☐Unknown 9 Unknown ģ or Vital Records, P. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has b page 2 s performed certificate 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospic 2 ER/Outpatient 3 DOA 2 NO 2 1 ☐ Yes 1 Inpatient this After this funeral 28a. Date of Injury (Month, Day Year) 27. Manne f Death 1 atural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at er To the Funeral Dire 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 21136 mb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 750 Mainst. terstown 5 C 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1:00 P M Louis W. Zekiel 2007 July 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore f Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug 23, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Hours Days 216-18-9380 1 XM 2 ☐ F 84 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore Parkville 1 ☐ Yes 2 ☐ XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd, Apt 1325 21234 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 XYes 2 No WW II If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Department of Elementary/Secondary (0-12) College (1-4or 5+) Press Officer Education d 2 should be filed v h and Mental Hygie 7 Is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Zekiel Anna Lisowska ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley H. Zekiel-wife 8810 Walther Blvd, Apt 1325, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillton Serv Corp 7/10/07 4 □ Donation 5 □ Other (Specify) Towson, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician unnons /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical signed by the attendin I be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) W SPLU Hospital: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

10+1

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Zekie

Lowis

wn

32. Registrar's Signature

Charles St RENSON NO

07-05058	
Katty Andrea	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- For State Criticate of Death Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No.	4 U U	100
	Physici	an/	1. Decedent's Name (First, Middle,Last)	Mont	of Death h Day	Year	3. Time of Death 1310 hrs
viedica	il Exami	ner	Katty Marie Andrea  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Loc		2, 2007	County of Death	13101115
			Anne Arundel Medical Center Annapolis	oation of Boati		ne Arundel	
F	Funeral				e of Birth(MM/D	D/YYYY) 9. Birt Foreig	hplace (State or
D	Director		519-11-8737 1 M 2 X F 22 Yrs. Months Days	Hours Min. 2/	20/1985	Col	untry) ID
	any.	4. #* .7	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
n .		ř	MD Anne Arundel Fort Meade				1 X Yes 2 No
	vfaryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	E 2 3 5	10g. Citize	en of What Cour	ntry?
	th the Maryland 23a or 28a-f sho notified at once.		2920 Unit B Fernandez Ct. 2075			USA	
	ath will items	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, M			4. Race - Ameri White, etc.	can Indian, Black,
,	fler de l'', or		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No	specify:		Specify: W	hite
ally dela a	ours a	d be	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation during most of working life. Dr		e 16b. Ki	nd of Business/	ndustry
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene, is a standard of the Saar Saar Saar Saar Saar Saar Saar Saa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Military Desk			Hote1	
215-0036	ed with tygiene other t	Som		.Mother's Name (First, N			
[215	uld be file Mental H marked c c event, tl	Be	3	Michelle Mc			
D 21		P	19a. Informant's Name/Relationship (Type, Print )  Caleb Andrea Husband   2920 Unit B Fe				
e, MD	l and 2 Health: item 2	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemel			ocation - City or	
nor	ages lant of I		Burial 2 X Cremation 3 Removal from State  A Donation 5 Other Specify:  Removal from State crematory or other place)  Heritage Crematory	7/10/20	007 Sp	okane,	WA
Baltimore,	permit. Pages I Department of F Important: If i	1 1	21. Signature of Fu eral Service Licensee 22. Name and Address of		_		
0.4			23a Part I. Eriter the disease, or complications that caused the death. Do not enter the mode of dying, su	Ave. Annapo	lis, MD	21401	Approximate Interval
	ysician Medical		failure. List only one cause on each line.		itory arrest, snot	JK, OI HEAIT	Between Onset and Death
•	aminer		If mediate Chuse (Final disease or condition resulting in death)  a. Can lications of narcotic intoxication of condition resulting in death)  Due to (or as a consequence of):	n			-
			Sequentially list conditions, b.				
		nine	if any, leading to immediate Due to (or as a consequence of):  Course: Enter th deriving Course (Disease or injury that initiated Co				
	ecuted and - transit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
	execuian and	Medical	UNPENDED AMENDED 27 22 C NE 200 7/12/0	7 000			
,09,	cate be ex physiciar he burial	Med	#23a_27_28a=fperMEg8697/13/0  IF FEMALE: 23c. If yes, outcome of pregnancy		23d	. Date of deliver	y
Box 687	leath certific e attending for use as t	sician	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy		Month	Day Year
So.	e death the atte ed for 1	Physi	1 Yes 2 No 9 V Unknown 9 Unknown				
P.O.	that the ned by detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23		, , , , , , , , , , , , , , , , , , , ,	the cause of death?
Js, F	quires t en sign uld be	ted 1		24	a. Was an		itopsy findings available
Division of Vital Records,	law re has be e 2 sho	Completed			autopsy performed?	death?	completion of cause of
Re	riant The certificate actor, page		25. Was case referred to medical 26.Place of	f Death (Check only one	Yes 2 No	1 🗸 Y	es 2 No
Vita	ysicia this cer direct	o Be	avaminar?	ther Nursing Home	5 Resider	nce 6 Othe	r.
o c	ling Ph After t funeral	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury 1 Natural 5 Page 19 Natural 1 Yes		escribe how inju	ry occurred	
sior	I or Attend after death Director: d in by the	catic	Pending Pending Page 1 Page 2 Accident Series Place of Injury - At home, farm, street, factory, office built		ink	nd Number or Ri	ural Route Number, City
Divi	tal or At rs after d ral Direct lled in by	Certification:	3 Suicide 6 X Could not be determined (Specify) unk		Town, State)	id Natiber of it	arai reduce reamber, only
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butous after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	and place, and due to	the cause(s) and		
	To the Ho within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d and manner stated.  29b. Signature and title of certifier 29c. License r				
		2	29b. Signature and title of certifier  29c. License r  O.C.M.			Date signed (Mo	nini, Day, Fearj
	(f)		30. Name and address of person who completed cause of death (Item 23a)				
	UKN-		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimor	e, MD 21201			
	S	tate	31. Date filed (Month, Day, Year) 32. Renstrar's Signature				

# amend line 26 per phy aaco hith dept 6/25/07 dlw Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_			1 - State Registrar	Department of Health and I Certificate of Death	Mental Hygiene Reg. No. 007	22090
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Henry Adams Jr.		2. Date of Death Month Day Year 6/19/2007	3. Time of Death  11:00ath
	Exami		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis thday) If Under 1 Year   If Under 24 Hrs.	Anne A	rundel
	Funeral Director		5. Social Security Number 402-30-3842 6. Sex Y M 2 F 7. Age (In yrs. last birt. 81	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		rthplace (State or Foreign Junitry) Kentucky
	e Maryland a-f show	ctor	MD 10b. County 10c. City, Town Anne ARundel De	n or Location ale		10d. Inside City Limits 1 Yes 222No
	with the	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any highly or other treumstic event, the Medical Examination that closing any place.	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 M Yes 2 □ No WWII If Yes, Give Year or Dates:	20751  13. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerting The Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)  14. Race - Am Black, Wh  Specify:	
21215-0036	thin 72 hou 6. an "natura Medical E	Completed	15. Decedent's Education 16a.	Decedent's Usual Occupation (Give kmd of work done during most of wor life. DO NOT use retired)		,
	d be filed wi antal Hygien ted other th	Be	12 C  17. Father's Name (First, Middle, Last)  Henry Adams		Rail Roadine (First, Middle, Maiden Surmame) ie Click	d
Maryland	nd 2 should alth and Me 27 is mark	2		Mailing Address (Street and Number or Ru		Zip Code)
Baltimore,	Pages 1 a nent of Hea int: if Item iry or othe		1XXBurial 2 Cremation 3 Removal from State	Disposition (Name of y, crematory or other place)	Date 20c. Location - City o  2/2007 Davidsonvi	
Balti	permit. Departnimporte		21. Signature of Funeral Service Lightnee	22. Name and Address of Facility Har 12 Ridgely Ave. Ann	desty Funeral Homo	e, P.A.
8760,	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cause) Due to (o	Heart Faile Antery Disea	re	Approximate Interval Between Sheet and Death Sheet and Death Sheet
O. Box 6	The death certific by the attending pached for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of de Month	olivery Day Year
rds, P.	quires that in signed t uld be det	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
il Records,	: The law requir cale has been si page 2 should l	Completed	Renal Insufficiency			utopsy findings available completion of cause of
Vital	yeicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?    Hospital: 1   Inpatient 2   FR/Outs	Othor	th Check only on	
ion of	ding h. After fune	ation: To	27. Manner of Death 28a. Date of Injury 28b. Ti	patient 3 XDUA 4 Nursing H	ome 1116 de 6 □Other (Spe 28d. Describe how injury occurred	ecify)
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fame building, etc. (Specify)	n, street, factory, office	28f Location (Street and Number or R City or Town, State)	lural Route Number.
	To the Hospital or within 24 hours after To the Funeral Director of gompletely filled in I	Medical	29a. Certifier (Chol. a.f.) 1 Certifying Physicien: To the best of my knowledge, (Chol. a.f.) 2 Medical Examiner. On the basis of examination and and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	, and due to the cause(s) and manner a rred at the time, date and place, and du	s stated. e to the cause(s)
	To the within To the	Me (	29b. Signature and title of centuer	29c. License number	29d. Date signed (Mon	th, Day, Year)
	00		30. Name of address therson who completed gause of death (Item 23a) (The state of the state of t	Type, Print)  Reuse Huy, A	nuasalis MA	1. 2144
	Sta Registr		31. Date filed (Month, Day, Year)  32. Red Trains Signature  JUN 2 5 2007	hade	, we	7 - 1101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Thomas Webster Bell June 24, /Medical 12:50 a 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown Mary's 5. Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F Months Days Hours Director 70 217-34-1280 01/14/1937 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show items 23a or 28a-f sh ner must be notified Director 1 ☐ Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or items or or other traumatic event, the Medical Examiner must be r 42025 Breton Bay Farm Road Completed by Funeral 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Dealership Owner Automotive Dealer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Thomas Webster Bell Mary Catherine Sterling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other trau Dorothy G. Bell/Wife P.O. Box 353, Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/27/2007 | Helen, Maryland Oueen of Peace Cem 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Laux disease or condition resulting in death) inmona /Medical insequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tra Due to (or as a consequen Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1∏ Yes 2 No i or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 P No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 🕼 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitai 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) 30. Name and address of period who completed of use of death (Item 23a) (Type, Print) Jarboe 4035 Three Notch Road, Hollywood, MD James P. 31. Date filed (Month Day) State 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and of the viand Perpander 870 Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** Jack Anthony Buonauro, Jr. Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 19, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1953 № M 2 🗆 F Illinois Director 53 319-40-4278 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No r 28a-f sh notified Directo Westminster Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or : traumatic event, th. Medical Examiner must be n death v Funeral 334 Pollen Ct 21157 . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: Specify: White à 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Design Engineer Lever Brothers 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be in nent of Health and Mental Jack A. Buonauro, Sr. Elizabeth Gabriz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Westminster, MD 21157 334 Pollen Ct. Susan Buonauro 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/26/2007 DesPlaines, Illinois All Saints Cemetery Princes Funeral Whome and Chapel, P.A. 21. Signature of Funeral Service Licenses 412 Washington Road Westminster, MD 21157 23a. Part. Enter the disease, or samplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. NON-SMALL-CELL LUNG CANGER Immediate Cause (Final disease or condition resulting in death) METASTATIC Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consecuence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1☐Yes 2☐No sate has been signed by the a page 2 should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? at or Attending P Certification: (Month, Day Year) Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10 State Registrar

WISL

3altimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

31. Date filed (Month, Day, Year)

FRANCIS

KHOO, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 MEMORIAL

D30263

AVE, WESTMINSTER, MD

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			30. Name and add	ress of person who cor	npleted cause of death (Iter	n 23a) (Type, Print)	•	,	(	Alm 3:3//-		
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20 2007 June 8:20A Juanita Bailey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Part | Days | Hours | Min. | Sept 25 19 Genesis Elder Care @ Anne Arundel Spa Creek 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 92 Yrs. 1915 Maryland 214-05-2143 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1 Des 2 No notified Maryland Anne Arundel Annapolis Director within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re 21403 USA 302 Hilltop Lane Apt A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Specify: Black 1 ☐ Yes 2 No 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th None 2yrs Homemaker Pages 1 and 2 should be filed nent of Health and Mental Hygiant: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Spriggs Anita Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 302 Hilltop Lane Apt A Annapolis, Md. Wyatt Bailey(Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 6-27-07 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Ambleme Revaces of acid ons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final N Perinber Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consecuence of Examine certificate be executed burial-trans and Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached for ☐Yes 25Ho 9∏Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 TYes 2 No 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA P 1 Inpatient this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

Medical State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of 31. Date filed (Month, Day,

29b. Signature and title of centier

29a. Certifier

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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			Registrar	1 - 45			Cer	tificate	OI L	Jeani —		2. Date of De	Reg. No.			3. Time of Death
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ite; INIAI yilailu ZIZIOJOO 8 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			Yvette Hopkin				269	Silve	rle	eaf	Ct.	Arnol	d, N	1d.	2101	.2
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COLOS, P.O. BOX or w requires that the death certific been signed by the attending p should be detached for use as:	A S	M	IF FEMALE:	23c If we	e outcom	e pf pregna	DCV							00-l D-		
ath cer attendir for use	2	a	23b. Was decedent pregnant in the past 12 months?	1 1	Live birth	2 □ Fetal at time of de	Ideath 3	]Ectopic preg ] Other (spec							te of delive onth	Day Year
the g	1.0	3810	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown	at time of de	eauri SL	JOHIer (Spec	шу)							
that the			Part II. Other significant condition	ons contributing	g to death	but not resu	ulting in the u	nderlying cau:	se give	en in Part	I.	23e. Did	tobacco u	use cont	ribute to th	ne cause of death?
signe d be	2	2	Atrosity									1 🗆	Yes 2	<b>□</b> -No	3 Prob	ably 4 Unknown
hecolus, he law requires t has been signe ge 2 should be o	1	Completed by	000									24a. Was	s an	24b	Ware auto	psy findings available
has has ye 2 s	1	<u>D</u>										auto			prior to con death?	mpletion of cause of
in: The			OF Man and referred to modical							00 51	( D II	1□ Yes	2 No		1 ☐ Yes	2 No
VILAI siclan: T certificat rector, pa	10		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	4 🗆 🛩	N1 0 0 1	ER/Outpatier	* 20 DOA	Othe	ar.		(Check only		a 🗆 au	(0 :	
Physical display	- [6		27. Manner of Death		Date of In	jury	28b. Time o		: Injury Work	4 L N		me 5 Res 28d. Describe				y)
or Attending frer death. Director: Afte in by the fune	ء و		1 Natural 5 Pendin 2 Accident investig	g	(Month, D	lay Year)	Injury	м		k? Yes 2 [	]No		•			
dear dear ctor	100	200	3 Suicide 6 Could r	not be	Place of it	njury - At ho	me, farm, str	eet, factory, o	office						er or Rura	Il Route Number,
fer Dire	1	Certification	4 ☐ Homicide determ	illed	building,	etc. (Specify	V)					City or To	own, State	9)		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director After this certificate has completely filled in by the funeral director, page 2.				g Physician:												
ne Ho 1 24 h ne Fu	19	Medical	(Check only 2 Medical one)	Examiner: On and	the basis d manner :		tion and/or in	vestigation, ir	n my o	pinion, de	eath occur	red at the time	e, date an	d place,	and due to	the cause(s)
To th withir To th comp	N N	M	29b. Signature and title of certifie	//		_		29c. L	License	number				-		Day, Year)
2 10	V		Still	4	a	10		7	55	851	10		6	118	107	-
Net	7	1	30. Name and address of person		d cause of	death (Item	23a) (Type,	Print)		7.0			300			
10				40	1	ym	<u> </u>									
	State		31. Date filed (Month, Day, Year)	2007	32. egis	trar's Signa	ture	book								
Regi	stra	r	JUN Z A	, 2001	140	we s	er 19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20h per fh 8869 7-11-07 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Day 2007 **Physician** 2, Thomas Μ. Bracy 9:07A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Director 240-72-2741 60 Sept.10,1946 NC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 Yes 2 No Director Md. PG Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 7111 Berkshire Drive 20748 Funeral United States 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1⊠Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Completed by 3 Widowed 4 Divorced Black "natural", other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed withir lealth and Mental Hygiene. m 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Information Tech. Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Ransom Bracy Lizzie Dugger 7111 Berkshire Drive Camp Springs, Md. 20748 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If item 27 is any Injury or other trau Marsha Bracy/wife Camp Springs, Md.

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State  $7/\frac{1}{6}/07$ Md. 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem. Cheltenham, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, 20746 23a. Part Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYDCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner I Hecords, P.O. Box 68760, E.
The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatly? DIABETES 1 Yes 2 No 3 Probably 4 Nonknown HYPERTENSION 24b. Were autopsy findings available prior to completion if cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) cal and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40324 JULY 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

TERRY JODRIE, MD
31. Date filed (Month, Day, Year)

JUL 1 0 2007

3 Registrar's Signature

7503 SURRATTS ROAD, CLINTON, MARYLAND 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 7:35 PM June James Theodore Burns /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 12808 Circle Drive Rockville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 220-44-0610 94 Director Nov. 13, 1912Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 □Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12808 Circle Drive 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21☑ No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Doctor Private Practice 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be America Virginia Byrnes Charles Edward Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Treehaven St., Gaithersburg, MD Christine Kelly-Daughter 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐Removal from State Q Ft. Lincoln Crematory 06/21/07 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service License 1040 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 40 years a Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Failure to thrive 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2□ No this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

P.O. Box 68760 Division or Vital Records, To the Hospital or Attending Physician: within 24 hours a To the Funeral C

> State Registrar

31. Date filed (Month, Day, Year) JUN 25

29b. Signature and title of certifier

Joseph Kennedy, M.D.-5530 Wisconsin Ave., #1400, Bethesda, Maryland 20817 gistrar's Signature

and manner stated.

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

2007

29c. License number

D0013187

29d. Date signed (Month, Day, Year)

June 18, 2007

Certificate of Death

Rea. No

22, 2007

June

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Physici<u>an</u> Month рм Harold Joseph Babcock 20. 9:16 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 ☐ F Director 212-24-3018 80 Oct. 6, 1926 Pennsylvania Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Maryland Howard Highland 1 ☐ Yes 2√☐ No Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? must be n 7158 Brooks Road 20777 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items dical Examiner mi 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1944-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Concrete Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Curtis Babcock Lydia Blanche Nantais 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Mabel S. Babcock/ Wife 7158 Brooks Road, Highland, MD 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 25, 4 Donation 5 Other (Specify) Silver Spring, Maryland 2007 22. Name and Address of Facility
Francis J. Collins Funeral none

500 University Blvd, W. Silver Spring MD 209

Approximate Approximate Interval Between Onset and Death 21. Signa r of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Septic Shock Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Chronic Obstructive Airway Disease burial-tra Due to (or as a consequence of). Box 68760. physician Physician/Medical Congestive Heart Failure the attending p IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2X No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 X Natural 5 Pending investigation Injury 1 □ Yes 2 □ No after death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 29a, Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) **JUN 2 5** 2007

Suzan Abdo, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D50870

5005 Signal Bell Lane, #202, Clarksville, MD 21029

			<b>1 - State Amend Item 24a per State</b>	laryland / Depa verb., 8869, Cel	ortment of Healt 07/25/07dhb tificate of Dea	th and Me eth	ental Hygie Reg	ene 1. No.2 () () 7	22099	
Г	Physici	ian	Decedent's Name (First, Middle, Last)  FVOIV	n S. Booth			2. Date of Death Month	Day Year	3. Time of Death	
1	/Medic		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Locat	ion of Death	Jun 1	9, 2007 4c. County of Deal	12.00 1	
A. C.	LAdiiii	iei	6555 Skinners Turn Road	ı		wings		Calvert		
\$ \$ \$	Funeral Director		212-54-3791 ¹□M 2ĂF	ge (In yrs. last birthday) 88 Yrs.	If Under 1 Year If Un Months Days Hou		8. Date of Birth (Month, Day, ) May 10, 1	rear) Co	hplace (State or Foreign untry) Maryland	
	/land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	e Maria-f sh tified	ctor	MD Calvert		O۱	wings		1 □Yes 2X No		
	with th a or 28 t be no	Dire	10e. Street and Number 6555 Skinners Turn Road		10f. Zip Code	0736	100	. Citizen of What Co U.S	*	
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ If Yes, Give	No	│ Was Decedent of Hispanic f Yes, specify Cuban, Mex		14. Race - Ame Black, White	e, etc.		
003	hours tural",	ed by	3 Widowed 4 □ Divorced Year or Dates:			City.	1 46	Specify: Blac		
Maryland 21215-0036	within 72 liene. r than "na the Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give	lent's Usual Occupation kind of work done during a DO NOT use retired)  Domestic		g   16	Someone El		
and 2	d be filed ental Hygi ced other c event, tl	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Ollie Smit	:h	18. M	lother's Name (	First, Middle, Ma	uiden Surname)		
Maryl	nd 2 should be f ith and Mental I 27 is marked ot traumatic even	70	19a. Informant's Name/Relationship (Type. Print) Florence Gray /Daughter	City or Town, State, 2	Zip Code)					
Baltimore,	Pages 1 and 2 nent of Health ant: If item 27 i ary or other tra		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place)  JMC Cemetery	Da 06/23		oc. Location - City or Sunderla	,	
Baltii	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service Licensee  Sladene G. Sewel I		. Name and Address of Fa Sewell Funera		l Prince Fre	derick, MD 20	,	
	Physician /Medical Examiner	iner	resulting in death)  Due to (or as Sequentially list conditions.	d the death. Do not entrine.  ORONARY s a consequence of):			DISE		Approximate Interval Between Onset and Death	
,8760,	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last  C  Due to (or as	s a consequence of):						
O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1							
rds, P.	quires that n signed t uld be det	by	Part II. Other significant conditions contributing to death to Severe Perupheral	out not resulting in the ur	derlying cause given in Pa	art I.	23e. Did toba	. /	the cause of death?	
Division or Vital Records,		Completed	3) Bildent old 3) Seizure de	· cerabs	I enfor	ection	24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of 2 No	
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati	ent 2∏ER/Outpatien	Other:		(Check only one)			
on or	Attending Physrdeath. ector: After this by the funeral di		27. Manner of Death  1	ury 28b. Time of	28c. Injury at Work?  M 1 □ Yes 2	28	e 5 Lingesidend 3d. Describe how	ce 6 ☐Other (Specinjury occurred	cify)	
Divisi	= <b>=</b> # # <b>5</b>	Certification:	3 Suicide 6 Could not be determined 28e. Place of in	jury - At home, farm, stre tc. <i>(Specify)</i>			If. Location (Stree City or Town,	et and Number or Ru State)	ıral Route Number,	
	the Hospital hin 24 hours of the Funeral mpletely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or inv	occurred at the time, dat vestigation, in my opinion,	e and place, ar death occurred	nd due to the cau d at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)	
	To t Withi To t	Ž	29b. Signature and title of certifier M	Depart.	29c. License numb	per 127	290	Date signed (Mont)	h, Day, Year)	
_	4		30. Name and address of person who completed cause of a A. MUNSAI. M.D. (10	death (Item 23a) (Type, I	D 194 Print) PR. FRE	PER	1 CK	m D 20	678	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist	ra Signature	Accide to					

DHMH 17 Rev 1/2001

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		ertificate of			Reg. No	2007	22100	
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of De Month	Da	y Year	3. Time of Death	
	/Medic	cal	ODELL O. CRC	USE		4h City Town o	r Location of Death	June	3	0 2007 County of Death	3:00 PM	
	Examir	ier	, , ,		er	Bel Air				Harfo	rd	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth									
	Director		214-16-7220	]M 2□F 89	) Yrs	Months Days	Flours Will.	2/22/	1918	Nort	h Carolina	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or	Location				1	10d. Inside City Limits	
	Maryl f sho ied a	jo	MD Harford		Darl	ington					1 ☐ Yes 2 No	
	n the	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Cou	ntry?	
	death with the Maryland ms 23a or 28a-f show r must be notified at	ralD	4021 Conowingo Ro	ad		210				USA		
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1 □ Never Married 2□ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give* Year or Dates:		3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 【 No	Specify:	ecify Yes or No Rican, etc.)			etc. hite	
7.5	n 72 h "nat	lete	15. Decedent's Edi (Specify only highest grad	de completed)	16a. De	cedent's Usual Occup ive kind of work done e. DO NOT use retire	pation during most of work d)	king	Ī	(ind of Business/In		
22	withii iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		pervisor	-/		Ci	vil Serv	ice	
20	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	•		n Surname)		
ylar	Menta	2	William F. Crouse	2				E. Caud				
o7 3	l 2 sho		19a. Informant's Name/Relationship (7)		1	ailing Address <i>(Street</i> 20 Conowing				,		
	1 and Healtl em 27		Dennis O. Crouse/S			sposition (Name of crematory or other pla		Date		ocation - City or To		
6/3 %	Pages ment of tant: If it jury or o		¶∏ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	) I	cemetery, o Dublin	Southern (	Cem. 7/5/	2007	Dar	lington,	MD	
Ball	permit Depar Impor any In		21. Signature of Funeral Service Licens	Lovelia	1	22. Name and Address Harkins Fi	-	me, Inc	., I	elta, PA	17314	
<u>1000</u>	Physician /Medical		23. P. 11. The the dis ase, or comp hock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		15	enter the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
~	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Diseases or injury that initiated events	b Due to (or as a cons	sequence of):							
200	tificate be execured g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):							
0/// 6876(	tificate be ig physicia as the bur	ledical		d								
6 00 O. Box	ires that the death certif signed by the attending d be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death	3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	у			23d. Date of deliv Month	rery Day Year	
S, P	quires that en signed b uld be deta	þ	Part II. Other significant conditions of	Mar.	resulting in th	e underlying cause gi	ven in Part I.				the cause of death?	
Orc	w requir been si should	sted	pneumoi	m.							bably 4 □Unknown	
De// Vital Récords	The law cate has b	Completed						24a. Was auto perf 1∐ Yes		prior to co death?	opsy findings available ompletion of cause of 2 No	
Vita	Physician; this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea					
0.5	Phys r this ral dir	To	1 ☐ Yes 2 ☐ No  27. Mannal of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpa 28b. Tim	ment 3 DOA	4 ☐ Nursing H	ome 5 ☐ Res 28d. Describe		6 □Other (Speci	ify)	
ión	Attending death.	ation	1		r) Inju		rƙ? ]Yes 2 □No					
use División	il or Atte after des I Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - A building, etc. (Sp		street, factory, office		28f. Location ( City or To		ind Number or Rur te)	al Route Number,	
Cro	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my iner: On the basis of exan and manner stated.	knowledge, d nination and/o	eath occurred at the tor investigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time	cause( , date a	s) and manner as and place, and due	stated. to the cause(s)	
`	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. D	ate signed (Month		
			DINGHA	400		De	15985	7	Ju	14 157	200/	
	q		30. Name and address of person who of	500 (2	pper	pe, Print) Chusap	eake	Dr. ve	B	el Air,	1207 MD 2/078	
	Sta Regist		31. Date-filed Month, Day, Year)	7 Registrar's S	ignature	nection						

07-05109 Joseph Adam Costlow

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

17	125	-	ery	173	13	1	0
2	U	U	1	2	6		U

		I- For State Certificate	of Death	Reg.		
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)  Joseph A. Costlow		2. Date of Death Month Da July 4, 2007	ay Year	3. Time of Death 0358 hrs
•		4a. Facility Name (if not institution, give street and number)  Rt. 50 E/B near Hall Road	4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda		. 8. Date of Birth(	MM/DD/YYYY) 9. Birth	
Director		202-66-7860 1XM 2F 20	Yrs. Months Days Hours Min	12/10/	1986 Foreign	intry) PA
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
* *	٥		ashington TWP			1 Yes 2 X No
5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Director	10e. Street and Number 8036 Lofty Heights Drive	10f. Zip Code 17268	10g.	Citizen of What Coun USA	
ath with items 23.	Funeral	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
fter de		3 Widowed 4 Divorced If Yes 2 X No	Yes 2 X No specify:		Specify: V	white
ours a	od b		edent's Usual Occupation (Give kind of an most of working life. DO NOT use ret		6b. Kind of Business/Ir	ndustry
5-0036 led within 72 hours Hygiene. other than "natur	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Partner		construct	ion co.
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	O	17. Father's Name (First, Middle, Last)  Charles D. Costlow	1	e (First, Middle, Mai na M. Dev		
2121 Ild be fil Mental I narked event,	o Be		ailing Address (Street and Number or			, Zıp Code)
2 sho	٦		036 Lofty Heights			
			sposition (Name of cemetery, or other place)	Date 2	20c. Location - City or	Town, State
Pages hent of ant: I		St. Ar	drew Cemetery 07/	/09/2007	Waynesbo	ro, PA
Baltimore, permit. Pages 1 and Department of Heal Important: If iten injury or other tra		21 Sign ture of Funeral Service Licensee	22. Name and Address of Facility TOV 50 S. Broad St.,	ve-Powers Waynesbo	ox Funeral ro,PA 1726	Home, Inc.
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
'Medical aminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			- 2	Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	iner	if any, leading to immediate cause. Enter Underlying Cause				
the day	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
execu ian an	/Medical	UNPENDED AMENDED			•	
760, icate be physic the bur	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 68760, re death certificate be the attending physicine for use as the burner of for use as t		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	ancy	Month [	Day Year
BO) e death the att	Physiciar	1 Yes 2 No 9 Unknown g Unknown		Log Billion		the raye of double?
P.O. that the ned by detach	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		acco use contribute to 2 ✓ No 3 Prol	
ords, F w requires is been sign should be	sted			24a. Was an		utopsy findings available
e law r e has b	Completed			autopsy perform 1 ✓ Yes 2	ned? death?	completion of cause of es 2 No
tal Rec cian: The certificate ector, page	ပ္ပ	25. Was case referred to medical	26.Place of Death (Check			2
Vita tysicia this cer direct	To Be	examiner?  1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other Nurs	ing Home 5 R	esidence 6 🗸 Othe	r: Scene
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		27. Manner of Death       28a. Date of Injury       28b. Tin         1 Natural       5 Pending       Jul (Month Pay Year)       0355 h	e of Injury 28c. Injury at Work?  1 Yes 2 No		ow injury occurred to involved in mo	tor vehicle
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm		28f. Location (Stror Town, Sta	ate)	ural Route Number, City
D ospital hours meral y filled		4 Homicide determined (Specify) Major Road / High			r Hall Road, Berlin,	
To the Hos within 24 h To the Fur	edical	one) 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred	at the time, date ar	nd place, and due to the	ne cause(s)
To with Con	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	onth, Day, Year)
		higher, mo	O.C.M.E.		July 5, 2007	
5		30. Name and address of person who completed cause of death (Item 23a)	Street, Baltimore, MD 21201			
	nto.		Street, Baltimore, IVID 21201			
اد Regis	tate trar	31. Date filed (Month 10ay, Year) 0 2007 32. Begistrar's Signature				

DHMH 17 Rev 1/2001

Registrar

2007

CH-10

Registrar
DHMH 17 Rev 1/2001

DR. VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
JUN 28 2007

			For State Registrar	State of M	aryland / I	Departme Certifica			and M		iene	07	22104	
	Physici /Medic Examir	cai	1. Decedent's Name (First, Middle LUCY 4a. Facility Name (If not institution 458 Cranes Ro	n, give street and number)	OFLIT			Location o		2. Date of Dea Month	Day VO 4c. Count		3. Time of Death  2001 M  Arundel	
	Funeral Director		5. Social Security Number 027–03–2842	6. Sex 1 ☐ M 2 XE 7. Ag	ge (In yrs. last bii 95	Yrs. If Under Months	r 1 Year	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day Aug. 22	Year)	9. Birthp	place (State or Foreign ntry) sachusetts	
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne	Arundel	rundel 10c. City, Town or Location Annapolis						10d. Inside City Limits 1 ☐ Yes 2000			
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 458 Cranes Roos	t Court		10f. Z	p Code	21	409	1	0g. Citizen of	What Coun		
9036	72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show calcel Exertified at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Marri  3 ☐ Vidowed 4 ☐ Divorced	If Yes Give	?	13. Was Dece If Yes, spo		ispanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, fy: W		
Maryland 21215-0036	d within giene. r than "	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 10	t's Education st grade completed) College (1-4or		Decedent's Usi (Give kind of w life. DO NOT) Machine	ork done d ise retired	during most ()		ing	16b. Kind of B	susiness/Ind		
land	g d a g	To Be (	17. Father's Name (First, Middle, Salvatore Pulve	,						(First, Middle, I lasile	Maiden Sumar	ne)		
, Mar)	d 2 sh th and 7 is m traum		19a. Informant's Name/Relations!  Joseph Sampugna							Annapa Annapa			and 21409	
Baltimore,	permit. Pages 1 am Department of Heali Important: If itam 2 any injury or othar once.		20a. Method of Disposition  1 ▼ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)  21. Signature of Funeral Service	pecify)	cemete		other place Cept nd Addres	ion	6/26 y Joh	/2007 1 n M. Tay	ylor Fu	e, Ma neral	assachusett	
8760,	death certificate be executed  Wedical  Washington and  After the burial-transit	ledical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or as	a consequence	UI):	f	+ RT,	En	a Dis	EASE		Interval Between Onset and Death 37M4)	
.O. Box 68	he death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al	2 Fetal death	3 □Ectopic p 5 □ Other (s						ite of delive	ery Day Year	
rds, P.	signed signed d be de	by	Part II. Other significant conditio	ns contributing to death b	out not resulting i	n the underlying	ause give	en in Part I.			pacco use con	tribute to th	ne cause of death?	
Vital Records,	The law ate has b page 2 sh	Completed							_		y ned? 2 IÚ No	prior to con death?	psy findings available mpletion of cause of 2 No	
of	Attanding Physician: 3 r death. actor: After this certifical by the funeral director, p	ertification; To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  16 Natural 5 ☐ Pendin, investig  2 Accident 6 ☐ Could n	Hospital: 1  Inpatie 28a. Date of Inju (Month, Da pation	y Year) I	Time of njury	28c. Injury Work 1 🗀 `	ar: 4 □ Nur	rsing Hon 2 No	28d. Describe ho	once 6 ∏Oth	red		
=	Hospital or Attan 24 hours after deat Funaral Diractor: stely filled in by the	0	4 Homicide determine 29a. Certifier 15 Certifying	28e. Place of Inj building, et g Physician: To the best	c. (Specify)			a data as-		28f. Location (St. City or Town	ı, State)			
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical I one)  29b. Signature and title of certifier	Examiner: On the basis of and manner sta	f examination an ated.	d/or investigation	, in my or	oinion, deat	h occurre	ed at the time, da	ate and place,	and due to	the cause(s)	
)	⊢ <i>≱</i> ⊢ ŏ		Hospice o	f the Chesa	reake M	any		21438	3		6/2	1/0	7	
4	CH		Michael J. La		, 445 De			ay, Ar	nnapo	olis, MI	21401		_	
	Sta Registr		JUN 2	2 2007 32. Registr	w K	Apart								

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To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital within 2

n 24 hours after death.

e Funeral Director: A letely filled in by the fur filled in by

Ana Rubio MD. Assistant Medical Examiner State 2007 Registrar

3

Medical

Suicide

29b. Signature and title of certifier

4 V Homicide 29a. Certifier

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

(Specify) Parking Lot

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

28e. Place of Injury - At home, farm, street, factory, office building, etc

28f. Location (Street and Number or Rural Route Number, City

June 20, 2007

29d. Date signed (Month, Day, Year)

or Town, State) 14707 Shiloh Court, Laurel, Md.

			Plea										•		Legible	·.		
		for State		Sta	ate of Ma	arylan					lealth D <i>eath</i>		lental Hy	•	200	7	22	105
		Registrar  1. Decedent's Name	e (First, Middle	e. Last)				Cert		9 01 1	Deaui		2. Date of D	Reg. N	o.C. U U		3. Time o	
Physicia		Leonard Leon Chapman									Month Day Year June 19 2007				8:	50 ам		
/Medic Examin		4a. Facility Name (II	f not institution	n, give street	and number)		4b. City, Town, or Location of Death				of Death	4c. County of Death				-		
		Prince Ge							If I laday		everly	04 Ura			Prince			
Funeral		5. Social Security N		6. Sex 1 ☑ M 2		e (In yrs. I			If Under Months	Days	If Under Hours	Min.	8. Date of B	lay, Yea	r)	Countr	y)	or Foreign
Director		290-28-96 Usual Residence of				73							December	18,	1933   1	Alab	allia	
ryland thow	Ļ	10a. State	10b. County			10c. City	y, Town	or Loca	ation							10	d. Inside (	
ne Ma 8a-f s atiflec	Director	Maryland	Montg	omery					Silve		ing							5 2√ No
with ti a or 2 be n		10e. Street and Nur		D					10f. Zip	Code	2000/-			10g. C	itizen of What		y?	
ns 23	Funeral	11. Marital Status	913 Lode	12. W	as Decedent	Ever in U.	S.	13. W	/as Deced	lent of H	20904 ispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - A		n Indian,	
after o	Fur	1 Never Marri	ied 2X Mar	ried 1	med Forces? ☑Yes 2☐ I Yes, Give	No			Yes, spec ☐ Yes		an, Mexica Specify		Rican, etc.)		Black, W	hite, et	tc.	
ural",	d by	3 Widowed	4 Divorced	Ÿe	ear or Dates.	952-19									Specify:	B1a		
"natu	lete	(Spec	15. Deceden cify only highe	t's Education st grade com	pleted)		1 (	(Give k	ent's Usua aind of wor O NOT us	k done	durina mos	st of work	ing	16b.	Kind of Busine	ss/Indu	ıstry	
within iene. than the M	Completed	Elementary/Seco	ndary (0-12)	C	ollege (1-4or 8 2	5+)	j				.es Mai	nager			Me	dia		
e filed Il Hyg other	BeC	17. Father's Name (	(First, Middle,	Last)							18. Moth	er's Name	e (First, Middle	e, Maide	n Surname)			
Menta Menta arked	To E	James	s Edward	Chapmar	1							Hest	ella Busi	by				
2 sho and is ma rauma		19a. Informant's Na													or Town, State		,	
1 and Health Sm 27 ther to		The 1 ma B.		n - Spot	ıse	20h P			odest ition <i>(Na</i> n		rive,		er Spring Date	1	ryland 2 Location - City			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifled at once.		1⊠ Burial 2	☐ Cremation		al from State	B1u	emetery 1e Wi	, crema ng B	atory or o Baptis	ther plac t	œ)		/2007		oro, Nor			12
nit. Partme artme ortani injuri		4 Donation  21. Signature of Fu			V	Ch	nurch		netery Name an		ss of Facil		2007	ROAD	oro, nor		arorri	
Dep Imp any		Nam	A	. Ten	ee	5/	e						Home, Ind		Spring,	Marv	land 2	20904
		23a. Part1. Enter the shock, or hea	he dispase, or	r complication only one cau	ns that caused use on each li	the death	n. Do no										Approxima Interval Be	ate etween
Physician		Immediate Cause ( disease or condition	Final	a	Septic											1	Onset and	Death
/Medical Examiner		resulting in death)			Due to (or as		uence of	f):							•			
Examine:	7	Sequentially list con	nditions,	b	Multiple Due to (or as			f):								-		
uted I Insit	Examiner	cause. Enter Unde Cause (Disease or	rlying injury	<	Ventila			•	Respi	rator	y Fail	lure						
exect an and rial-tra	Еха	that initiated events resulting in death) l		С	Due to (or as													
ficate be executed physician and is the burial-transit	ical			d												_		
ertifica ling pl	Physician/Medica	IF FEMALE:		200 - 16		=f =												
leath cer attendin for use	ian/	23b. Was decedent in the past 12	months?	1	yes, outcome □Live birth □Pregnant a	2 Fetal	I death		Ectopic pr Other (sp		1				23d. Date of Month		y Day	Year
at the de by the stached	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown			Unknown				0.1101 (0)									
de de tr	by PI	Part II. Other signif	ficant conditi	ons contribut	ing to death b	ut not resu	ulting in	the und	derlying c	ause giv	en in Part	l.	23e. Did	tobacco	use contribute	e to the	cause of	death?
w requires been signi should be													1	) Yes	2 ☑ No 3 ☐	Proba	bly 4	]Unknown
law ras be	Completed													opsy		to com	sy findings pletion of	s available cause of
sician: The law certificate has l irector, page 2 s													1□ Yes	formed?	death 1 ☐ Y		2□ No	
siciar certif	o Be	25. Was case refer examiner? 1 ☐ Yes 2 ☑		Hospit	al:	ant 2□	EB/Outr	nationt	3 🗆 DC	Oth	er.		h (Check only		6 □Other (S	(6.)		
g Phy er this eral d	-	27. Manner of Deat	h		a. Date of Inju	iry	28b. Ti			8c. injur Wor		ursing Ho	28d. Describe			pecny)		
endin sath. or: Aff	atio	1 ☑ Natural 2 ☐ Accident	5 ☐ Pendir investi	gation	(WOHIT, DO	y real)	,	july	М		Yes 2	]No						
or Att	Certification:	3□ Suicide 4□ Homicide	6 ☐ Could detern		e. Place of inj building, et	ury - At ho c. <i>(Specif</i> )	me, farr v)	m, stree	et, factory	, office			28f. Location City or To		and Number or ite)	Rural	Route Nu	mber,
To the Hospital or Attending Physician: within 42 Hours after death. To the Furneral Director: After this certifies completely filled in by the funeral director; to		29a. Certifier	1 🔀 Certifyii	ng Physician	: To the best	of my kno	wledge,	death	occurred	at the tir	ne, date a	nd place,	and due to th	e cause	(s) and manner	r as sta	ited.	
he Ho n 24 h he Fu pietel)	edical	(Check only one)	2 Medical		on the basis on the manner st		tion and	l/or inve	estigation	, in my c	pinion, de	ath occur	red at the time	e, date a	nd place, and	due to	the cause	(s)
To t To t	Σ	29b. Signature and	tile of certifie		1				290	Licens	e number			29d. D	ate signed (M	onth, D	lay, Year)	
D		911	of c	Me	HO.	_		Market State	1	6-1	15/	//		b	12/	0.7	<u></u>	
		30. Name and addr Ophnell A								ve. (	Thever	1v. M:	arvland	20785				
Sta	ite	31. Date filed (Mon	th, Day, Year)		32 Anistr	ar's Signa	ture	-		. v = , (	MEVE!	-y, 116	ar y rand	-0100				
Registr		J	UN 25	2007	Beth	ار ری	or ,	4										

DHMH 17 Rev 1/2001

			1 - State Registrar		epartment of Health and Certificate of Death		ene	22107
			Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Time of Death
	Physici		Elbert Clifton Cul	llipher		June 21	Day Year 2007	5:10 a M
	/Medic Examir		4a. Fecility Name (If not institution, give street		4b. City, Town, or Location of De		4c. County of Deatl	
В			Hillhaven Nursing Ce	enter. Inc.	Adelphi		Prince Ge	orge's
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 H		9. Birtl	hplace (State or Foreign untry)
	Director		241-32-1946 1½ M	81 Y	rs.			rth Carolina
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Aaryli F sho	ō	Maryland Frederic		derick			1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number	,,,,	10f. Zip Code	10	g. Citizen of What Co	A
	with Ba or		129 Willowdale Dri	ive, Apt. 44	21702	"	USA	and y
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examinar must be notified at	Funerai	11. Marital Status 12. W	as Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ame	rican Indian,
·^	fter o	Έ	A	med Forces? ☐ Yes 2 ☐ XNo	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White	
ဗ္ဗ	urs a	by	- C	Yes, Give ear or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:Whi	te
9	72 ho	Completed	15. Decedent's Education (Specify only highest grade com		Decedent's Usual Occupation	working 1	6b. Kind of Business/	Industry
21	thin and and and and and and and and and an	pje		ollege (1-4or 5+)	Give kind of work done during most of v life. DO NOT use retired)	vorking		
7	ed wi	Son	12		Manager		Manufactu	ring
n	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's N	lame (First, Middle, M	aiden Sumame)	
<u> </u>	Meni Meni arka	ပ္	Herbert Asa Cullin		Lucy	nora Sim	pson	
Maryland 21215-0036	2 sh and Is m		19a. Informant's Name/Relationship (Type, P.		Mailing Address (Street and Number or			
~	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Ita Madical Examinat must be notified at once.		Tu Thi Cullipher/Wif		9 Willow Dale Driv			
Itimore,	Jes 1 Fita	,	20a. Method of Disposition 1	cemetery	Disposition (Name of crematory or other place)	Date 22,	Oc. Location - City or	Town, State
Ē	. Pag imeni tant:		' 4 ☐Donation 5 ☐ Other (Specify)	Gate of	Heaven Cemetery	2007 S:		ng, Maryland
Ball	ermit epar npor ny in		21. Signal re o Funeral Service Licensee	100	Figure and Address Cofficiens	s Funeral H	Home Inc.	
_	007 e d		melien >		500 University Blv			, MD 20901
١.			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one say	is that caused the death. Do no se on each line.	ot enter the mode of dying, such as card	iac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Aspiration Pneu	monia			Onset and Death
П	/Medical Examiner		resulting in death)	Due to (or as a consequence of	):			
В	Examine	_	Sequentially list conditions,	Dementia				
	sit sit	Examiner	cause. Enter Underlying	Due to (or as a consequence of)				
	ecut and I-tran	хап	that initiated events c.	Coronary Artery  Due to (or as a consequence of				
8760,	ate be executed obysician and the burial-transit			Hypertension	·			
687	the the	dicai	d	ny per cension				
ŏ	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If	yes, outcome of pregnancy			23d. Date of deli	nen.
B	atter for u	ciar	in the past 12 months?	Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
o.	the d the ched	ysi		Unknown	o El Ottion (opposity)			
٦	res that the de signed by the a be detached f	F P	Part II. Other significant conditions contribut	ing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	uires sign ld be	d by				1 ☐ Yes	s 2□No 3□Pro	obably 4XTUnknown
Record	w requ been should	Completed				24a. Was an	24h Were au	topsy findings available
Re	o _ o	ф				- autopsy perform	prior to death?	completion of cause of
Vital	i <b>ician</b> : Th certificate rector, pag	e Co	25. Was case referred to medical		00 Bl 45	1 Yes 2	35	2 No
	Physician: r this certific ral director,	o Be	examiner?  1 Yes 2 No	al: 1  Inpatient 2 ER/Outp	Othor	eath (Check only one	nce 6 ⊡Other <i>(Spe</i> d	1, 2,
ō	Phys or this oral dir	$\vdash$		a. Date of Injury 28b. Tin		28d. Describe how		ary)
0	th. : After s funer	ıtlor	1 ★Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inju	ury Work? M 1 ☐ Yes 2 ☐ No			
Division of	II or Attandi after death. Director: A d in by the fu	flea	a Could not be	e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		eet and Number or Ru	ral Route Number,
á	al or after Dire	Certification;	4 Homicide	building, etc. (Specity)		City or Town,	State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physician	: To the best of my knowledge,	death occurred at the time, date and pla	ice, and due to the car	use(s) and manner as	stated.
	na Ho 24 na Fu	edicai	(Check only 2 Medical Examinar: Cone)	In the basis of examination and/ and manner stated.	or investigation, in my opinion, death or	curred at the time, dat	o and place, and due	to the cause(s)
	withir To the	ž	29b. Signature and title of certifier	7.,	29c. License number	29	d. Date signed (Month	n, Day, Year)
	_		> Stun ?	M	D4699	وي الا الا	0/21/2	DO 4
	10		30. Name and address of person who complete	ed cause of death (Item 23a) (T	ype, Print)			
			Steven Tee, M.D.	3415 Hamilton	Street, Hyattsvill	e. MD 2078	31	
	Sta	te	31. Date filed (Month, Day, Year)	32. Projetrar's Signature				
	Registr	ar	JUN 2 2 2007	Degre &	Grand			

07-04696 Leona Craid

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1-For State Certificate of Waryland / Department of Certificate of		Reg. No.	2007 2210
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Examiner	LEONA S. CRAIG		June 19, 2007	1625 nrs
	4a. Facility Name (if not institution, give street and number) 4922 LaSalle Road	4b. City, Town, or Location of Death Hyattsville		e George's
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs		YY) 9. Birthplace (State or
Director	578 28 6513 1 M 2XF 84 Yrs	Months   Days   Hours   Min	05/31/1923	Foreign Country) MS
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	on		10d. Inside City Limits
<b>8</b> .⊓	MD PRINCE GEORGES UPPER MAR	LBORO		1 Yes 2 X No
the Maryland a or 28a-f show tified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of	What Country?
th the N 23a or notified	10010 TIMERWOOD COURT	20772		ED STATES
5-0036 led within 72 hours after death with the Maryland ftygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Completed by Funeral Director	1 Never Married 2 Married Armed Forces? If Y	s Decedent of Hispanic Origin? ( Spes, specify Cuban, Mexican, Puerto		ace - American Indian, Black, /hite, etc.
ral", or	1 Yes 2 X No 3 X Widowed 4 Divorced of Yes Give Yeer 1	Yes 2 X No specify:	Specia	fy: BLACK
5-0036 led within 72 hours after their "natural", other than "natural", other than "natural", Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Deceder during m	it's Usual Occupation (Give kind of vost of working life. DO NOT use reti		Business/Industry
5-0036 ed within 72 hour stygiene other than "natu the Medical Exar Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  1YR.  TRATI	NING SPECIALIST	FED	ERAL GOVERNMENT
5-00 led with tygien other	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surna	
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than file event, the Medica To Be Comple	GEORGE SCOTT  19a. Informant's Name/Relationship (Type, Print )  19b. Mailini	SYLVANI g Address (Street and Number or		Four State 7: Code
MD 2 d 2 shoul lith and N n 27 is n numatic		GAITHER ST. TEMP	r	
ore, MC ss I and 2 sl of Health an If item 27		sition (Name of cemetery,	Date 20c. Location	on - City or Town, State
imore, MD 2 Pages 1 and 2 shou nent of Health and I land: If item 27 is n or other traumatic	4 Donation 5 Other Specify: RESURRECT	ION CEMETERY 06	/26/2007 CLI	NTON, MD
Baltimore, pernit Pages 1 a Department of He Important: If ite	21 Signature of Funeral Service Licensee 22. N	lame and Address of Facility ARSHALL'S FUNERA 308 SUITLAND ROA	L HOME OF MAR	YLAND, INC.
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as cardiac	or respiratory arrest, shock, or	heart Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a. Hypertensive Atherosclerotic Card	ovascular Disease		Death
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,			
iner	if any, leading to immediate Due to (or as a consequence of):			
red msit Examiner	(Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):			
xecute n and I - tran	dd			
68760, certificate be executed noting physician and isse as the burial - transit ciann/Medical Exi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date	e of delivery
687 certifica iding p se as th	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregn	ancy Mont	h Day Year
). Box 687 the death certific by the attending p tched for use as th Physician/	1 Yes 2 ✓ No 9 Unknown 4 Pregnant at time of death 5 Of	ther (Specify)		
P.O. I se that the gned by the detache	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.		ontribute to the cause of death?
Records, P.O. Box 687: The law requires that the death certificate has been signed by the attending, page 2 should be detached for use as t Completed by Physician/	End stage renal disease, diabetes mellitus			Probably 4 Unknown      Were autopsy findings available
Cord law ret has be 2 2 shor			autopsy performed?	prior to completion of cause of death?
Vital Rec ysician: The I his certificate I director, page o Be Corr	25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 No	1 • Yes 2 No
Vital hysiciam this certi Il directo	examiner? 1. ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	Other		6 Other: Scene
Division of Vital Records, ra derections and after the law requirers after death.  The law rection: After this certificate has been seled in by the funeral director, page 2 should bertification: To Be Completed.	27. Manner of Death 1 ✓ Natural 5 Popular 28a. Date of Injury (Month, Day,Year) 28b. Time of	Injury 28c. Injury at Work?	28d. Describe how injury oc	curred
ivision or Attenc after death Director: In by the	2 Accident Investigation 28e Place of Injury - At home farm stre		28f. Location (Street and No	umber or Rural Route Number, City
Division o spital or Attending hours after death. neral Director: Aft r filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or Town, State)	,
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	rred at the time, date and place, and	d due to the cause(s) and mar	nner as stated.
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner:On the basis of examination and/or investiga and manner stated.  29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
_   *	10-1 1 1 3 740	O.C.M.E.	June 20	
	30. Name and address of person who completed cause of death (Item 23a)			
+6	7.0011.0	Penn Street, Baltimore, M	D 21201	
State Registrar	31. Date filed (Month, Day Year) 32. Registrar's Signature 32. Registrar's Signature 33.			

DHMH 17 Rev 1/2001 OCME 2006

07-046	94	
lamar	K	Dennis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 [] [] 7
State of Maryland / Department of Health and Mental Hygiene

		- For State egistrar	Cer	tificate of l	Death		Re	g. No.		
Physicia		Decedent's Name (First, Middle,Last)	Middle,Last) 2. Date of Death 3. Time of Dea							
ledical Examin		LAMAR K.	J)E	NNIS			Month June 19, 2	Day Year 007	1552 hrs	
		a. Facility Name (if not institution, give stree	and number)	4b	. City, Town, or L	ocation of Deat	th	4c. County of Dea	ath	
		Peninsula Regional Medical Ce	nter		Salisbury			Wicomico		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hr	rs. 8. Date of Birtl	h(MM/DD/YYYY) 9. E	Birthplace (State or	
Director					Months Days			Ear	nian .	
Director	-	212-41-14-28 1×M :	F 13	Yrs.			4-2	3-1-1-14	Country) MARY AND	
	- 1	Usual Residence of Decedent	Jan- Oit	Town or Location					10d. Inside City Limits	
w any	1.	10a. State 10b. County							1 Yes 2 No	
and sho	ь/	PARULAND Wicomico	5	PALISON	RY		y C. ma			
Maryland 28a-f show d at once.	ᄫ	10e. Street and Number	1		10f. Zip Code		10	g. Citizen of What Co		
th the Maryland 23a or 28a-f sho notified at once.	Director	207 WEST LOCA	STRI	EE)	2180	1		U.S.A		
with s 23.			Vas Decedent Ever in U.	S. 13. Was	Decedent of Hisp	oanic Origin? ( \$	Specify Yes or No-	14. Race - Am	erican Indian, Black,	
eath item	uneral	1 Never Married 2 Married	rmed Forces? Yes 2 No	If Yes	s, specify Cuban,	Mexican, Puerl	to Rican, etc.)	White, etc.		
ter d	<u> </u>	3 Widowed 4 Divorced If Yes,		1 \	res 2 No	specify:		Specify:	Slock	
irs af	함-	15. Decedent's Education (Specify only high	es:	16a. Decedent's	S Usual Occupati	on (Give kind of	f work done	16b. Kind of Busines	s/Industry	
PROPOSED TO STREET  10g. Citizen of What Co								10.0		
36 lin 7 lhan dical	쁿	07	,	at.	udent			NONE	=	
with with her her	탕	17. Father's Name (First, Middle, Last)		271		8 Mother's Nan	ne (First, Middle, N	Maiden Surname)		
7. E.	Be C	GREGORY DEN	Nis					mith		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica		19a. Informant's Name/: elationship (Type, P		19h Mailing	Address (Street			ber, Çity or Town, Sta	ate Zin Code)	
ID 2 shou and N 7 is n	_	MARY ANN Smith	Molher	207 V				soury,		
MD and 2 shc alth and 2 is 27 is raumati		20a. Method of Disposition		Place of Dispositi			Date	20c. Location - City		
F = E = F		1 Burial 2 Cremation 3 Re	I .		a minas)			1 ' '		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify:	50	peinahi)	/ MEMORY	PARCEN	6-23-07	Salisbu 821 Wes	ery, Md.	
Salti Sermit. Separtin mporti njury o	ı	21. Signature of Funeral Service Licensee		22. Na	me and Addres	of Facility	(1)	821 WES	Rono	
E P P E		Glady B. Ster	rart	SE	woel /	CUNERS	1 -JOME	SALISBU	184, Ma 21801	
Physician	ヿ	23a. Part I. Enter the disease, or complication	ns that caused the death	. Do not enter the	mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	pproximate Interval	
/Medical	37	failure. List only one cause on each line  Immediate Cause (Final disease a Drow							etween Onset and Death	
Examiner	- 1		(or as a consequence o	f):						
1		_								
	힐	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence o	rf):						
	힐	cause. Enter Underlying Cause (Disease or injury that initiated								
a t	Examiner	events resulting in death) Last Due to	(or as a consequence o	f):						
= 7 a		d							<del></del>	
760, cate be executed physician and the burial - transi	읭	UNPENDED	ENDED							
of Vital Records, P.O. Box 68760, g Physician: The law requires that the death certificate be ex.  After this certificate has been signed by the attending physician neral director, page 2 should be detached for use as the burial			. If yes, outcome of preg					23d. Date of deliv		
688 e as t	Ē,	past 12 months.	Live birth	- 4)	al death 3	Ectopic preg	nancy	Month	Day Year	
Box 68 e death certif the attending ed for use as	Sic	1 Yes 2 No 9 Unknown a	Pregnant at time of de	eath 5 Oth	er (Specify)					
he de f	Physiciar		Unknown	- 141 1- 41		ives in Dest I	23e Did to	hacco use contribute	to the cause of death?	
ords, P.O. Box 68:  w requires that the death certification is seen signed by the attending should be detached for use as it.	اھ	Part II. Other significant conditions contr	buting to death but not re	esulang in the ur	idenying cause g	iven in Fait i.			robably 4 Unknown	
S, F	둜			<del></del>			-			
regular peer	뺼						24a. Was autop		autopsy findings available to completion of cause of	
e law	Completed						perfor	med? death 2 No 1 ✔		
tal Rec		25. Was case referred to medical	<del></del>		26 Place	of Death (Chec		2 10	103 2 110	
vision of Vital Rec or Attending Physician: The I fter death. Director: After this certificate I in by the funeral director, page	ă۱	examiner? Hospita	lia Innationt 2 of	ER/Outpatient		Othor:		Residence 6 Ot	her:	
f Vi Physi er this	유	1 ✓ Yes 2 No 27. Manner of Death 2	Ba. Date of Injury	28b. Time of In		y at Work?		now injury occurred		
1 of Jing Pl After funeral	崩	1 Natural 5 Pending	(Month Day Year) Jun 19, 2007	0340 hrs		res 2 No	Subject drov			
ivision or Attendenther death Director:	烹	2 Accident Investigation								
Division of Vital Records, tal or Attending Physician: The law requirers after death.  The Director: After this certificate has been so be in the funeral director, page 2 should be in by the funeral director, page 2 should	ğ۱	3 Suicide Could not be	8e. Place of Injury - At h	ome, farm, street	, factory, office b	uilding, etc.	or Town, S	tate)	Rural Route Number, City	
Divisio To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director Completely filled in by the	Certification:	Tronnoido	Specify) River				Williams Land	ling <sup>°</sup> , Salisbury , M	D	
160s 24 h Furr		29a. Certifier 1 Certifying Physician: To (Check only)								
Fo the within Fo the Comple	Medical	one) 2 Medical Examiner:On the	e basis of examination a nanner stated.	and/or investigation	on, in my opinion	, death occurred	d at the time, date	and place, and due to	the cause(s)	
F ≥ F/2	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (i	Month, Day, Year)	
ND		my his v	W		0.0.1	M.E.		June 20, 2007		
7	-	30. Name and address of person who comple	ated cause of death (Item	n 23a)						
100			al Examiner 111		, Baltimore.	MD 21201				
U			32. Registrar's Signati		.,					
Sta Regista		31. Date filed (Month, Day, Year)  JUN 2 2 2007	Sz. rugistar s orgitali	He A.	M					
		00 N N L001	- July Mary							
DHMH 17 Rev 1/20	01			ORIGINAL						

			1 - State State Registrar	e of Maryland / Depa <i>Ce</i>	artment of Health a rtificate of Death		ene g. No 200	7 22110	
4000	Physici /Medi		1. Decedent's Name (First, Middle, Last)	М.	Dexter	2. Date of Death Month June 23	) Day You	3. Time of Death 6:30 pM	
	Examir		4a. Facility Name (If not institution, give street an Union Hospital	d number)	4b. City, Town, or Location of Elktori	f Death	4c. County of Death Cecil		
\$.	Funeral Director		5. Social Security Number 192–12–7210 6. Sex 1X M 2	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth (Month, Day, Aug. 9,	Year)	Birthplace (State or Foreign Country) ssachusetts	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	1 □ Never Married 2 Married 1 □ Year 3 □ Widowed 4 □ Divorced Feature 15. Decedent's Education (Specify only highest grade complete)	de Forces?  \$\forces \text{2} \\ \$s, \text{Give} \\ \text{or Dates: WWII}    tetal)	10f. Zip Code  21921  Was Decedent of Hispanic Origif Yes, specify Cuban, Mexican,  1□Yes 2₺ No Specify:  dent's Usual Occupation kind of work done during most DO NOT use retired)  18. Mother  Lana  Ing Address (Street and Number  Cold Chestnut R  Position (Name of matory or other place)  Crematory  2. Name and Address of Facility	of working  Pethick ror Rural Route Number, Date  2/25/2007 L:	Black, W. Specify: Wh 16b. Kind of Busines Flooring faiden Surname)  City or Town, State Maryland 20c. Location - City inwood, P	merican Indian, hite, etc.  Lite  ss/Industry  2, Zip Code)  21921 or Town, State	
23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as case of shock, or heart failure. Unit only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
P.O. Box (	t the death certifi by the attending ached for use as	Physician/Me	in the past 12 months?	Pregnant at time of death 5[ Jnknown	□Ectopic pregnancy □ Other (specify)  nderlying cause given in Part I.	23e. Did tob:	23d. Date of o	delivery Day Year	
Division or Vital Records,	ding Physician:  After this certifica funeral director, p	Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  27. Manner of Death  1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	24b. Were prior to death 1 1 Yes.  24b. Were prior to death 1 Yes.  25c.  26c.  27c.  24b. Were prior to death 1 Yes.  25c.  26c.  27c.  27c.  24b. Were prior to death 1 Yes.  25c.  26c.  27c.  2	es 2DNo				
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	ical	(Check only 2 Medical Examiner: On	o the best of my knowledge, deat the basis of examination and/or in manner stated.	vestigation, in my opinion, deat	th occurred at the time, da	ate and place, and o	lue to the cause(s)	
<b>)</b> _	GOLVA		29b. Signature and title of entifier  30. Name and address of person who completed  31. Date filed (Month, Day, Year)  JUN 2 6 2007	cause of death (Item 23a) (Type,	Print) JOHL Stree	t Ste 3B	Elkho.	1 n MD 2/92	
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) JUN 2 6 2007	32. Registrar's Signature	posli				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2*0*0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Center Baltimo Maryland 8. Date of Birth (Month, Day Jan. 29 Birthplace (State or Foreign Country) Social Security Number <sup>Year)</sup> 1959 **Funeral** 1**X** M 2□ F Months Days Hours 152-58-5653 48 Director Kansas Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No ral", or items 23a or 28a-f sh Examiner must be notified Director Beltsville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4519 Elmwood Road 20705 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Hydrogeologist MD Dept. of Environment 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beverly J. Mason ပ္ Kenneth A. Douglas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau 4519 Elmwood Road, Beltsville, Maryland 20705 Diane P. Douglas, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ¹X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) George Washington Cemetery: June 25, 2007 Adelphi, Maryland 22. Name and Address of Facility Donald V. Borowardt Funeral Home, 4400 Powder Mill Road, Beltsville, 21. Signature of Funeral Service License Donal 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a nsequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an nis certificate has director, page 2 autopsy performed? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA ဥ 1 🔀 Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural
2 Accident 5 Pending neral Director; A investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

State

James

31. Date filed (Month

of person who completed

2007

\_ampagna inth, Day, Year) JUN 22 Med Center, 22 S. Greene St. Baltimore, MD 21201

of death (Item 23a) (Type, Print)

University of Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician М Doreen Douglas June 12, 2007 1928 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8111 Tahona Drive Langley Park Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🖾 F 579-76-0379 Director December 29,1922 Guvana Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director Maryland 1 ☐Yes 2X No Prince George's Langley Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or 8111 Tahona Drive 20783 U.S.A. death v Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify. þ 3 Widowed 4 Divorced Black Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: If Item 27 is marked other tha any Injury or other traumatic and once. 1 Seamstress Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Douglas Winifred Langford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Adams - Nephew 3509 Rhode Island Avenue, Mt. Rainer, Maryland 20712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 6/16/2007 Brentwood, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Hines-Rinaldi Funeral Home, Inc. <del>11</del>800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme if Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) physician Physician/Medical the as attending properties of the second IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown ģ signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed 1∐ Yes 2K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Nother (Specify) 2 2□ No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending Injury 1 X Natural 5 Pending Investigation n 24 hours after death.

The Funeral Director: A bletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 🗵 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

10

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

State Registrar

31. Date filed (Month, Day, Year) JUN 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvester, M.D., 3001 Hospital Drive, Cheverly, MD



H0055927

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 23a pt.11, 29d per doc 869 7-20-07 vt.

			america 1_ For 1_ State	State of	Maryland / Dep	partment of H			43 43 A 44	00110
			Registrar	41		Tillicate of i	Dealit	2. Date of Death	. No.	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Las	_				Month	Day Year	
	/Medic			Dunn				June	27 2007 4c. County of Death	5:30 P M
	Examin	er	4a. Facility Name (If not institution, give	street and num	ber)	4b. City, Fown, of	Location of Death			
			17326 Tamarack D		l A //o look bimb do	/) If Under 1 Year	liamspor If Under 24 Hrs.	8. Date of Birth	Washing	ton place (State or Foreign
	Funeral		5. Social Security Number 6. S	ex X M 2□F	'. Age (In yrs. last birthda)	Months Days	Hours Min.	(Month, Dav. Y	(ear) Cou	ntry)
Ma	Director		224-28-2804 Usual Residence of Decedent		82 Yrs.			Jan. 3,	1925 V	irginia
	and *		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	ed at	5				willi				1 ☐ Yes 2 🙀 No
	Ne N	Director	Maryland Washi  10e. Street and Number	ngton		10f. Zip Code	amsport_	100	. Citizen of What Cou	ntry?
	with a	급								,
	• 234	Funeral	17326 Tamarack D		dent Ever in U.S. 13	. Was Decedent of H	1795 Jispanio Origin? (Sn	acify Vas or No-	USA 14. Race - Ameri	can Indian.
	er de Item	nu	11. Marital Status	Armed For	ces?	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White,	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 【X Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2XINo	Specify:		Specify: WH	nite
21215-0036	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow Egal Extendings must be notified at		15. Decedent's Ed		16a Dec	edent's Usual Occup	ation	16	6b. Kind of Business/Ir	
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au	ntal od o	Be c					Contrad	o leono	Orndorff	
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Ma	h an 7 ier					es 27				
a)	permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie any injury or other trau		Allyson G. White 20a. Method of Disposition	- Daugh	ter 1/32 20b. Place of Dis	b lanaraci	K Drive W	Date 20	ort, Maryla  c. Location - City or T	and 21/95 own, State
Baltimore,	toff Fire		1 Burial 2 ☐ Cremation 3 ☐	Removal from S	itate cemetery, cr	ematory or other plac	ce)		•	
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<u>a</u>	appart apport		21. Signatur of Furrial Service (cer	Med M		TSBOTHE OF				21795
	207 2 9		lung 1-	X					liamsport,	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the death. Do not each line.	nter the mode of dyir	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(0	101/Ans	1 Ani	real	Dite	40	Onset and Death
100	/Medical		resulting in death)	a. Due to (c	or as a consequence of):	7	7			
	Examiner			_						
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	uted d ansit	声	if any, leading to almediate cause. Enter Underlying Cause (Disease or injury that initiated events							
<u> </u>	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Examiner	resulting in death) Last	Due to (	or as a consequence of):					
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89	ficate physics the	pa							1	
	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy				23d. Date of deliv	rery
Вох	atter for u	cia	in the past 12 months?			B Ectopic pregnancy Control Co	у		Month	Day Year
P.O.	that the de ed by the detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	wn		-2-			
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Division of Vital Records,	signed d be del	by	adole or	SURVE	no K	Xnor/A	W Dir	o 1 □ Yes	2 No 3 Pro	bably 4 DUnknown
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ě	2 5	du	CILOTIC ODSCIGO	cive pu	district direct			autopsy	prior to c	ompletion of cause of
=	ate pag	S						1 □ Yes 2	No 1 ☐ Yes	2 No
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.0	Attending death. ctor: Alt y the fun	ati	2 Accident investigatio	1		M 1 🗆	]Yes 2 □No			
Ξ	r Att	Ħ	3 Suicide 6 Could not be determined	28e. Place	of Injury - At home, tarm, ng, etc. (Specify)	street, lactory, office		28t. Location (Stree City or Town,	eet and Number or Rui State)	al Route Number,
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	ospitai hours a unerai		29a. Certifier 1 Certifying Pl	nysician: To the	best of my knowledge, de isis of examination and/or	ath occurred at the ti	me, date and place	and due to the cau	use(s) and manner as	stated. to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	and mann	er stated.	vosugation, in my (	ueatti occu			
	To the To the To the Comp	Σ	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month	, <i>Day</i> , Year) <b>-28-07</b>
	-					Di	Decer	50 -	6681	20 01
			30. Name and address of person who	completed caus	e of death (Item 23a) (Typ	e, Print)				~
SA	9+1		Lisa Higginboth	_	1110 Medica		DY Ha	mn.	21742	_
	St	ite	31. Date filed (Month, Day, Year)		gistrar's Signature	· Currier	141 (1/4)	9		
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 16 tate of Maryland, 68 presupporting Health and Mental Hygiene 1 - For A Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Fime of Death Year **Physician** 0844 M Drayton 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City\_Town, or Location of Death 4c. County of Death Examiner (Comico alisburi If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 KF Months Min Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Directo 10e. Street and Number 1000100 10f/Zip Code 10g. Citizen of What Country? 180 by Funeral 12. Was Decedent Ever in V.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married  $A \in \mathcal{L}$  ,  $C \in \mathcal{L}$  . Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping -th arade 10 FKC5 is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event; i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number/City or Town, State, Zip Code) 14.11207 Street Carlino 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility B Cen, 21. Signature of Funeral Service Licensee Box POCONUKC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Lum disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has page 2 autops, performed: or Attending Physician: filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Lopatient ပ 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer. Natura 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tive of certific 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar DHMH 17 Rev 1/2001 Cocean Year)

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JUN

31. Date filed (Month, Day,

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Coastal Hos

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#19a per TNF C869 7/11/07 WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JUNE 23. 2007 4:40A M JUANITA ELIZABETH DUDLEY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M **XX** F 10, 1930 WASHINGTON, DC JAN. Director 577 38 4951 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner πust be notified at 1 ☐ Yes XX No Director MD MONTGOMERY SILVER SPRING Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20902 2823 MUNSON STREET UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married XX Married 1 ☐ Yes ŽXNo Baltimore, Maryland 21215-0036 Specify Specify: Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", intal Hygiene. Led other than "natura c event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH PURCHASING CLERK FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be WILLIAM RUSSELL CROSON VIRGINIA ELIZABETH LARUE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARVEY A. DUDLEY, JR./SPOUSE 2823 MUNSON STREET SILVER SPRING, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. XIX Burial 2 Cremation 3 Removal from State CEDAR HILL CEMETERY 06/26/2007 4 ☐ Donation 5 ☐ Other (Specify) SUITLAND, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, m 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARREST **Physician** MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): HEART FAILURE Examiner LONGESTIVE MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Veal Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an certificate has t rector, page 2 s autopsy perform 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No after death.

I Director: /
d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOO 64560 JUNE 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year) JUN 2 6 200

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NIKHANI MD

Registra

ROCKVILLE MD 20850

			For State Registrar	State of Ma	aryland		rtment c			Mental Hy	giene Reg. No:	007	2211	5
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	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Tov	vn, or Locat	ion of Deat	th	4c.	County of Deat	h	
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	Funeral			Sex 7. Agr		ast birthday)	If Under 1 Y Months D	ear If Un ays Hou	ider 24 Hrs irs Min		rth ay, Year)	Co	hplace <i>(State or Fo</i> u <i>ntry)</i>	reign
	Director		190-42-9353	X	53_	Yrs.				09-30-	1953	PA		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Li	mits
	f ahc	ō	MD Baltim	ore	Tow	son							1 ☑ Yes 2 □	] No
	the t	ect	10e. Street and Number				10f. Zip Co	de			10g. Citi	zen of What Co	untry?	
	3a or	ā	509 East Joppa	Road			21	286				USA		
	ms 2:	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	3. 13.			Origin? (S	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame		
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	be filad within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23e or 28e-f ahow event, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	lent's Usual O kind of work o	lone durina	most of wo	orking	16b. Ki	nd of Business/	Industry	
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760,	The law requires that the death certificate ba executed tate has been signed by the attending physician and tate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	a consequ	ience of):								
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Viital	sicial certii recto	o Be	25. Was case referred to medical examiner?	Hospital:		FD/0-4	* "C DO#	Cthor		ath (Check only		2 Dothas (Coa	n/4.1	
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	7		20 E. Timor	ium rd #	209	7 11	mon	um	IN	102	109	3		
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			For State Registrar	<i>7</i> 1	ryland / Depa	artment of H	lealth and N	Mental Hyg	eg. No.	007	221	17
	Physici /Medic	al	Decedent's Name (First, Middle, Last)     BE     4a. Facility Name (If not institution, give s	RUCE ADELE	EVANS	4b. City. Town, o	r Location of Death		24,	2007	3. Time of I	Death A <sup>M</sup>
	Examin Funeral	er	Homewood at Crumla  5. Social Security Number 6. Sex	and, Farms	(In yrs. last birthday)	Frederi If Under 1 Year Months Days		8. Date of Birth (Month, Day, June 3,	th (Sy, Year)  Frederick  9. Birthplace (State or Foreign Country)			
Ω	Director		377−14−7901 1 Usual Residence of Decedent 10a. State 10b. County	M 27 F	90 Yrs. 10c. City, Town or Lo			June 3,	1917	917   Maryland   10d. Inside City Limits		
701	with the Maryland a or 28a-f show	Director	Maryland Frederick	τ	Frederic	10f. Zip Code		1	1 X Yes 2 No 0g. Citizen of What Country?			2 No
36	death	by Funeral Directo	7407 Willow Road  11. Marital Status  1 Never Married 2 Married  3 🖫 Wildowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give		21701 Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Display Rican, etc.)		U.S.A.  14. Race - American Indian, Black, White, etc.  Specify:		
Maryland 21215-0036	ithin 72 hours after ie. ien "natural", or Ita Medical Examine	Completed b									ite	
land 21	ould be filed with Mental Hygiene arked other the atic event, the	0	17. Father's Name (First, Middle, Last) Walter Benjamin Peppler  School Teacher  18. Mother's Name (First, Middle, Marth Adele Patt								n	
	is 1 and 2 should be to Health and Menta Item 27 is marked other treumatic events.	<b>L</b>	19a. Informant's Name/Relationship (Type Penelope Flowers/D	odbi		21797						
Baltimore,	nit. Page artment o ortant: If injury or II.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		20b. Place of Dispo cemetery, crem Smithsbur	g Cremat	ory 6/25	5/07	Smith		Mary1a	ınd
Ba	Dep Impe		21. Signature of Funeral Service Licensee  22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERA 1201 NORTH MARKET ST., FREDER  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								P.A. 21701 Approximate Interval Betw Onset and D	veen
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DODS 6/23/07

Known to physician as Bruce Evens

			for State	State of M	laryland / Dep	artment of H rtificate of L		, ,		
			Registrar  1. Decedent's Name (First, Middle, La	ist)	Ce	runcate of L	Jealli ————	2. Date of Dear	eg. No.	3. Time of Death
	Physici /Medi		Lawrence Fre		lin				2, Day 2007 Year	
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	Funeral Director		5. Social Security Number 6. \$ 214-28-9307	sex	ge ( <i>In yr</i> s. <i>last birthday</i> ) 75 Yrs.	Months Days	If Under 24 Hrs Hours Min		Year) C	rthplace (State or Foreign ountry)
Sight.	D	ji.	Usual Residence of Decedent					05 12	1952 (1851	
	larylar show	'n	MD 10b. County Prince G	eorge's	10c. City, Town or Lo					10d. Inside City Limits  122¥Yes 2 ☐ No
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	th with	a Di	4910 Lexington A	venue			20705		USA	,-
920	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	? No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☑ No	spanic Origin? (Sn, Mexican, Puel	Specify Yes or No- to Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White		
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Maryland	es 1 and 2 should b of Health and Ment fitem 27 Is marked r other traumatic e		19a. Informant's Name/Relationship (Blanche Hurley Es			ng Address <i>(Street a</i> Lex <b>i</b> ngton	and Number or Fi Avenue,	tural Route Number Beltsvil	r, City or Town, State, Lle,MD 20	Zip Code) 0705
Baltimore,	ages 1 ant of Herm: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, created	matory or other plac			20c. Location - City of	•
altin	permit. Pages of Department of Himportant: If ite any injury or of once.		4 ☐ Donation 5 ☐ Other (Special 21. Signa / e ) Funeral Service ☐ ce					A CONTRACTOR OF THE PARTY OF TH	imore Aven	
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Δ.	S L e	by Pr	Part II. Other significant conditions of	ontributing to death h	out not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ord	w require been signature should be	sted	-		<u> </u>			1 □ Y∈	es 2∐No 3∐P	robably 4 ⊠Unknown
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exar	niner: On the basis of	of my knowledge, death	h occurred at the tim vestigation, in my op	e, date and plac pinion, death occ	de, and due to the ca curred at the time, do	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner st	aidu.	29c. License	number	29	9d. Date signed (Mon	th, Day, Year)
		1	· Mille	Car	Ynu	D648	74		June 23,	
	(10)	/	30. Name and address of person who							
1			Shahab Bavani MD, 31. Date filed (Month, Day, Year)		n Dusen Roa	d, Laurel	, Maryla	and 2070	7	
	Sta Registr		JUN 2 6 2007	Teren J.	rar's Sign					

		Please Type or Print In	nd / Department of		
		For State Of Ivial year	Certificate of		Reg. No. 2011 2
0		Decedent's Name (First, Middle, Last)		2. Date	e of Death 3. Time of Death
Physic /Medi		Robert C. Goodman		JU	13, 2007 0650 M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death	4c. County of Death
		Doctor's Commenty	s last birthday) If Under 1 Year	ANATEL	Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (★ yrs 506-56-2374 1X M 2 F 6	Months Davs	Hours Min. (Mo	e of Birth 9. Birthplace (State or Foreign Country)  17, 1942 Washington DC
- An		Usual Residence of Decedent	<u> </u>	Aug.	17, 1942 Washington DC
ırylan show dat	_	10a. State 10b. County 10c. C	City, Town or Location		10d. Inside City Limits
he Ma 28a-f s otifie	Director		pper Marlboro		1 X Yes 2 No
with t a or 2		10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral	2003 Maple Leaf Place  11. Marital Status 12. Was Decedent Ever in		0774 Hispanic Origin? (Specify Yeban, Mexican, Puerto Rican, e	U . S . s or No- 14. Race - American Indian,
after (		Armed Forces?  1 ⊠SNever Married 2 Married 1 ⊠SYes 2 No			
ING ZIZISJOJOSO  be filed within 72 hours after death with the Marylan ttal Hygiene.  d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: N/A			Specify: Afro-American
n 72 t	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu (Give kind of work done	upation e during most of working ed)	16b. Kind of Business/Industry
within jiene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Policeman		D.C. Gov't.
nd Z be filed tal Hygid d other	O	17. Father's Name (First, Middle, Last)	_1.	18. Mother's Name (First,	Middle, Maiden Surname)
narylan 2 should be 1 and Menta 1s marked raumatic ev	일	Willie James Goodman		Margaret L	Gaskin
Miar d 2 sho th and T is ma traums		19a. Informant's Name/Relationship (Type. Print)	,		Number, City or Town, State, Zip Code)
e, n 1 and Health 9m 27 ther t		Maxine L. Chisholm  20a. Method of Disposition 20b.	319 Rittenhor	use St., N.W.	Washington, D.C. 20011  20c. Location - City or Town, State
partitinore, INIarylan permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any injury or other traumatic ev ones.	,	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory or other pl. Olivet Cem.	June 28,	The second secon
rmit. Pages partment of portant: If it y injury or older		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses			ce Funeral Service, Inc.
Dep Dep One		Dhomo B. Clistu			V. Washington, D.C. 20012
NI W		23a. Part1. Enter the disease, or complications that culsed the deshock, or heart failure. List only one cause on each line.			
Physician		Immediate Cause (Final disease or condition	schertic H	youTheir	e Heart Disease
/ /Medical Examiner		resulting in death)  Due to (or as a conse	equence of):		
Examino	<u></u>	Sequentially list conditions, if any, leading to limited atte	outes the		
uted nsit	Examiner	Cause (Disease or injury	quones siy.		
be executed ician and bunal-transit	Exa	that initiated events resulting in death) Last c	equence of):		
	ica	d			
death certificate attending physic for use as the	Physician/Medi	IF FEMALE:			
DOX sath cer	ian/	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pregnan	су	23d. Date of delivery  Month Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of	death 5 🗆 Other (specify)		
law requires that the as been signed by the 2 should be detached.		Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause g	iven in Part I. 23	e. Did tobacco use contribute to the cause of death?
w requires been sign	ed by				1 Yes 2 No 3 Probably 4 Onknown
aw re	Completed			248	a. Was an 24b. Were autopsy findings available
The The ate ha	E O				autopsy prior to completion of cause of death?  Yes 2 No 1 Yes 2 No
clan; ertific	Be (	25. Was case referred to medical examinar		26. Place of Death (Check	k only one)
Physic This c	6	1   Yes 2   No   Hospital: 1   Inpatient 2€	En Outpatient 3 DOA		☐ Residence 6 ☐ Other (Specify) scribe how injury occurred
dlng h. After funer	tion	Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury Wo	ork? ☐ Yes 2 ☐ No	scribe now injury occurred
Atter r deat ector	fica	3 Suicide 6 Could not be	home, farm, street, factory, office	28f. Loc	ation (Street and Number or Rural Route Number,
tal or safte	Certification:	4 ☐ Homicide determined building, etc. (Spec	ary)	City	vor Town, State)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my kr (Check only one) 1 ☐ Certifying Physician: To the best of my kr (Check only one) 2 ☐ Medical Examiner: To the best of my kr and manner stated.	nowledge, death occurred at the nation and/or investigation, in my	time, date and place, and due opinion, death occurred at th	e to the cause(s) and manner as stated. ue time, date and place, and due to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	29c. Licer	nse number	29d. Date signed (Month, Day, Year)
/-		I Halvadar / / Short	to DO H	2053927	Jme 14, 200
6		30. Name and address of person who completed duse of death (Its	em 23a) (Type, Print)	Dove C	Time 14, 200 leverle Mayland
	ate	at Date Stand (March Day Veral)   00 Participants Circ	- atura		2)
Regist		JUN 2 5 2007	& Species		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ANEND ITEM#3, perPHYS, G869, 7/10/07 WS

Certificate of Death 1 - For State Registrat 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** VIOLET GREER June LAURA /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 30 Locust Street Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1□ M 20 F 154-20-4172 Yrs. Director 82 Virginia Usual Residence of Decedent the Marylend 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or itama 23a or 28a-f ahow If a Medical Exaction most be notified at 1 Yes 2 No Director Carroll Westminster MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Locust Street 21157 Apt. 207 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whife, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed W Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Deportment of Health and Mental Hygiene. Important: if itsm 27 is marked other than "r any fijury or other traumatic avent, It a Mead any figure. Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Margie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) David A. Greer Sr. 1329 Cooptown Rd. Forest Hill, MD.21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Sfate 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/3/2007 Hampstead, Maryland Carroll Cremation! 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fibrillahon Atrial **Physician** Monic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner A. . Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit 14 470 Due to (or as a consequence of): Box 68760, Physician/Medicai serchlolesterilina IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute fo the cause of death? Records, ş 1 Yes 2 No 3 Probably 4 Winknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed 1 ☐ Yes 2 ☑ No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Tes 2 No 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funersi Direct 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 0054218 1eug 30 Name and address of person who completed cause of death (Item 23a) (Type, Print).

DR. Raman B Kaneua 3-R nal colon dure, West moster MD 211577 Kaneua Kaman 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State JUL 0 3 2007

DHMH 17 Rev 1/2001

Registrar

For	te		artment of Health and <mark>I</mark> rtificate of Death			
■ Reç	pistrar dent's Name (First, Middle, Last)		Tuncate of Death	Reg. I	No.	2 2 1 2 1
Physician		Henning		, Month	Day Year 1007	G + 2 = PM
/Iviedical	Madelin Varner ity Name (If not institution, give street and		4b. City, Town, or Location of Death	JUNE 2	4c. County of Death	17.35
LAdillilei	shington County		Hagerstown,		Washir	ngton
	Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Yea	9 Birthr	place (State or Foreign
	-50-6229 1□M 2□	f 100 Yrs.	World's Days Flours Will.	3/12/190	7 PA	10 y)
<u> </u>	te 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
Marylin Marylin M						1 ☐Yes 2 ☐ No
vith the Mar or 28a-f st be notified W	eet and Number	Hagers	10f. Zip Code	10g. (	 Citizen of What Cour	ntry?
h with	45 Jefferson St.		21740		USA	
tritems 23a inner must	tal Status 12. Was I	Decedent Ever in U.S. 13. d Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ Black, White,	
Te Arie affer	Never Married 2 Married 1 ☐ Y	es 2 No , Give No	1 ☐ Yes 2 ☐ No Specify:	o riioan, cio.)	Specify: White,	
be filed within 72 hours after death with the Maryland tital Hyglene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10° or	Widowed 4 Divorced Year	or Dates:	dent's Usual Occupation	10		
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tal Hyg	er's Name (First, Middle, Last)			ne (First, Middle, Maid	den Surname)	
To E G	ward Varner		Zelda	Kramer		
2 should and line in and Mer raumatic and line in a should be rearmatic.	ormant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street and Number or Ru	ıral Route Number, Cit	ty or Town, State, Zip	Code)
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ges 1 and 2 should be filed within 72 hours after death with the Marylan 10° 10° 10° 10° 10° 10° 10° 10° 10° 10°	thod of Disposition  Burial 2 □Cremation 3 □Removal fi	om State 20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 20c.	. Location - City or To	own, State
mii. Pages miii. Pages y Injury or o o o 121. Sige	Donation 5 Other (Specify)	New Beth	nlehem Cem. 7/2	2/2007 A1	iquippa	,Pa.
permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.	Dave L Street Licensee	/. #Mo1035	2. Name and Address of Facility Kas 547 8th St. Amb	sper-Hahn oridge,Pa	Funeral . 15003	l Service
23a. Pa	rt1. Enter the disease, or complications thock, or heart failure. List only one cause	nat caused the death. Do not en on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
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beat and the second of the sec	tially list conditions, eading to immediate Enter Underlying Disease or injury ated events					
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ysic ysic	7 Vac 21 2010 4 4	regnant at time of death 5 [ nknown	Other (specify)			,
that that that that that that the detacle detacle by	Other significant conditions contributing	to death but not resulting in the ι	underlying cause given in Part I.	23e. Did tobaco	co use contribute to t	he cause of death?
The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit ompleted by Physician/Medical Examir ompleted by Physician/Medical Examir ompleted by Physician/Medical Examir of the physician of t				1 ☐ Yes	2 No 3 Prol	bably 4 Unknown
The law required has been stoned and page 2 should				24a. Was an	24b. Were auto	opsy findings available
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hysic ce this ce all direct to To E	Yes 254No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatie		lome 5 ☐ Residence	e 6 □Other (Speci	fy)
tion: 7	Natural 5 ☐ Pending	Date of Injury Month, Day Year)  28b. Time of Injury	Work?	28d. Describe how in	njury occurred	
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bours y fille 29a. Ce	ertifier 15 Sertifying Physician: To	the best of my knowledge, dea	th occurred at the time, date and place	e, and due to the cause	e(s) and manner as s	stated.
he h he F he F plete		he basis of examination and/or in manner stated.	nvestigation, in my opinion, death occ	urred at the time, date	and place, and due t	to the cause(s)
29b. Sig	gnature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
	Cal		Proport Hager	٥	0-28-	2007
5H-3   ]	ne and address of person who completed	cause of death (Item 23a) (Type	Printy + 1/200	stown	Maryla	110
	or Waseem 1 be filed (Month, Day, Year) JUN 29 2007	126 Opal	COUFT Hage	3,000	7	neg-

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) HAUSHEER CHARIS Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 9. Birthplace (State or Foreign Country) Montgomery General Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1**X** M 2 □ F Director 25, 1924 Trinidad 074-18-8888 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any jury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Director NJ Union Scotch Plains 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1534 Ramapo Way 07076 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married XXMarried ¶XXYes 2☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 No Specify: White Specify: <u>^</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Walter Carl Hausheer Helen Marie Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LoPresto 712 Walnut Hill Road, Houkessin, DE 19707 /Son in Law Paul 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 2 2 Cremation 3 ☐ Removal from State Jun 27, 2007 4 Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Sign vure of Funeral Servic / icenses 500 University Blvd West, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician + cuto disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner 01011 OM attending physician and for use as the burial-trar Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9∏Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 **N**o 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 sl autopsy certificate 2 No 10 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient After this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 V Natural 5 Pending investigation 1 🗌 Yes 2 Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: death.

3altimore, Maryland 21215-0036

Certification: To

Medical

State Registrar

within 24 hours after death To the Funeral Director: filled in by

29a. Certifier (Check only one)	1 Certifyin 2 ☐ Medical
29b. Signature ar	d title of pertifie

3 ☐ Suicide

4 ☐ Homicide

6 Could not be determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

00065024

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monia GOMA

31. Date filed (Month, Day, Year)

9901 Medical Center Dr, Rockville, MD 20850

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Figure 26, perMD, 6/25/07, DFS, Modo Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 2007 Year Physician June 19, Chester A. Harding 4:00p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 802 Roxboro Road Rockville Montgomery 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 ☐ F 579-36-5650 78 May 18,1929 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 □Yes 2 □ No Directo Maryland | Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9445 Hickory View Place 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ki Yes 2 □ No 195 If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1951-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced 1952 Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) National Institute of Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Engineering Technician Standards & Technology marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Chester A. Harding Dorothy Coberth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Art Sessoms- Brother-in-Law 802 Roxboro Road, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Cemetery June 22, 2007 Rockville, MD 9 5 Other (Specify) 4 ☐ Donation 21. Significe of Funeral Service License 22. Name and Address of Facility Simple Tribute Eugen 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Malignant Neoplasm of Liver /Medical Due to (or as a consequence of): **Examiner** Malignant Neoplasm of Prostate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for seig coneequance off Examine be executed burial-transi Failure to Thrive Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Sister's home Other: 4 \sum Nursing Home 5 Residence 1 ☐ Yes 2 No P 1 | Inpatient 2 ER/Outpatient 3 DOA -6 ⊠Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760. Division or Vital Records,

death. spital or Attendl nours after death. neral Director: A / filled in by the fu Hospital 24 hours a within 24 hours a

To the Funeral L

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier (Check only

> 29c. License number D5505

> > SUITE

1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

JUNE

Attan Kasid, MD HOTHERS BURG

MD 20877

2007

State Registrar

31. Date filed (Month



and manner stated.

3. Time of Death

**Physician** /Medical Exam

**Funera** Directo

Baltimore, Maryland 21215-0036

6

**Physician** /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit

Division or Vital Records, P.O. Box 68760,

ner			sileer and number)	T7 '		4D. Oily, TOWII,				40.	na Chirt	COMB	37
4			lventist			If Under 1 Year	kvil		Date of Bird	- L		GOMER	
	5. Social Security N	10.0	ox 7. Age □M 2□F	e (In yrs. last b 68		Months Days		Min.	Date of Bird (Month, Dat Jan, 2	y, Year)	9. DI	thplace (Stat ountry)	_
<b>'</b>	215-34-				110.		ļ	L	an, Z	Z , I:	939 1	aryla	na
	Usual Residence of	10b. County		10c. City, To	wn or Loca	tion						10d. Inside	City Limits
5		,	omery		Mor	tgomer	v Vi	11age	7			1 <b>⊊</b> Y	es 2∐No
ect	10e. Street and Nu		, o.m.o.z. j			10f. Zip Code	7			10a Citi	izen of What C	ountry?	
ä	1946	4 Brassi	e Place			Tot. Zip Code	2088	36	İ	rog. Oil	U.S.A	-	
eral			12. Was Decedent 8	Ever in II C	12 W	ns Doodont of	Hispania O	rigin? (Specif	Voc or No		14. Race - Am	erican Indian	
Ę	11. Marital Status	ied 2 XMarried	Armed Forces?		IS. W	as Decedent of Yes, specify Cu	oan, Mexic	an, Puerto Rio	can, etc.)		Black, Whi		
S F	' 3 □ Widowed		If Yes, Give Year or Dates:	40	1[	⊒Yes ≱∏ No	Specify	y:			Specify: B	lack	
Be Completed by Funeral Director	/0	15. Decedent's Ed	ucation	16	a. Decede	nt's Usual Occu	pation			16b. Ki	ind of Business	/Industry	
jac	Elementary/Seco	ordary (0-12)	College (1-4or 5	+)	life. Do	nd of work done  NOT use retire		st of working				. 1 .	
Ö	L2t	n				Print	_				ith Li	tho C	.O
Be (	17. Father's Name	(First, Middle, Last)					18. Moth	her's Name (/			,		
2	WILD	ur G. Ha	ГТ (					Diai	che	Ciras	se 		
		ame/Relationship (7	ype. Print)	1		Address (Stree						20	886
		V. Hall	(Wife)			4 Bras						, MD	
	20a. Method of Dis		Removal from State	20b. Place cemer	of Disposi ery, crema	tion (Name of atory or other pl	ace)	Date	e	20c. Lc	ocation - City o	Town, State	
	4 □ Donation	5 ☐ Other (Specify	r)	Metr		neral							
1	21. Signature of Fi	ineral Service Licen	see	1-		Name and Addi						•	
Q	Fore	e K In	owdle !	O.C.		6 N. V					kville	,MD 2	0850
4	23a. Part1. Enter	he disease, or comp	olications that caused one cause on each lir	the death. Do	not enter	the mode of dy	ing, such a	as cardiac or r	espiratory a	rrest,		Approxin	nate Between
	Immediate Cause	(Final				rotic					1 60260	Onset ar	id Death
	resulting in death)			a consequence		TOCIC	Carc	ilovai	сата	<u> </u>	Locase	100	.1.5
	Conventially list or	n ditions	h										
ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate erlying	Due to (or as	a consequence	e of):								
ami	Cause (Disease or that initiated events	injury	c										
Ě	resulting in death)	Lasi	Due to (or as	a consequence	e of):								
Physician/Medical Examiner		•	d										
Med	IF FEMALE:												
an/	23b. Was deceder	i pregnani	23c. If yes, outcome 1 Live birth		th 3 □E	ctopic pregnan	су				23d. Date of de Month	elivery Day	Year
sici	1 Yes 2	□No	4□Pregnant at 9□Unknown	time of death	5 🗆	Other (specify).					WOTH	Day	Teal
Ph	9 Unknowr				:- Ab		i- D-d	4.1	00= Did 4		una nantributa i	a the sauce	of death 0
þ	Fait II. Other signi		ontributing to death b		in the und	enying cause g	iven in Pan	τι.			use contribute		
ted	cnr	onic Ren	nal Failu	ire					'	Yes 2	KINO 2 I F	robably 4	□Unknown
Completed	Chr	onic Obs	structive	e Pulm	onar	y Dise	ease		24a. Was auto	DSV	24b. Were a	utopsy findin completion o	gs available if cause of
O.	Thr	ombocyto	penia						perfo	rmed? 2X No	death?	s 2 No	
Be (	25. Was case refe examiner?							ce of Death (	Check only o	one)			
Tol	1 ☐ Yes 2 <b>X</b>		Hospital: 1 Inpatie			0 0011					6 □Other (Sp	ecify)	
ü	27. Manner of Dea 1 X Natural	5 Pending	28a. Date of Inju (Month, Day	ry 28b y Year)	. Time of Injury	28c. Inj			d. Describe	how inju	ry occurred		
äţi	2 Accident	investigation 6 ☐ Could not be					Yes 2						
Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of injubuilding, etc	ury - At home, c. (Specify)	farm, stree	et, factory, office		28	f. Location ( City or To	Street an wn, State	nd Number or F e)	iural Route N	umber,
ပိ	00 a Ca 4151 - 1	157 Cantifician Di	veision. To the hard	of mu knowl	an dest	annurrad at the	time data	and plant	al alua t- ti		\ and	o etets d	
Medical	29a. Certifier (Check only one)		ysician: To the best on niner: On the basis of and manner sta	f examination									e(s)
Me	29b. Signature and	I title of certifier				29c. Licer	ise number	r		29d. Da	te signed (Mor	th, Day, Year	·)
	Meca 7. Mistry MD D59738 6/21/07												

DHMH 17 Rev 1/2001

State Registrar 9901 Medical Center Dr, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Alicia Mistry,

31. Date filed (Month, Day, Year)

JUN 2 5 2007

leanor Hayden		State of Maryland / Department of Health and Mental H  - For State  Certificate of Death		eg. No. 20	67 2212					
Physician		Registrar 1. Decedent's Name (First, Middle,Last)	Date of Deat     Month	6 6 7 10	3. Time of Death					
ledical Examine		Eleanor Hayden	June 20, 2	2007	0100 hrs					
	ľ	4a. Facility Name (if not institution, give street and number)  3406 Metzerotz Road  4b. City, Town, or Location of Death  College Park	n	4c. County of D						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24Hr	s. 8. Date of Bir		. Birthplace (State or					
Director		412-56-0930 1 M 2 X F 72 Yrs. Months Days Hours Mir	01-24	1-1935 F	oreign Country) GA					
~ 8	_	Usual Residence of Decedent			10d. Inside City Limits					
ow any		10a. State 10b. County 10c. City, Town or Location			1 Yes 2 X No					
Maryland 28a-f show d at once	횽	MD Prince Georges College Park  10e Street and Number 10f Zip Code	1	0g. Citizen of What						
th the Maryland 23a or 28a-f sho notified at once	Director	3406 Metzerott Road 20740		USA						
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shu and the than "natural", or items 23a or 28a-f shu and the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( \$\)			merican Indian, Black,					
death or ite	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerton In Yes 2 X No	o Rican, etc.)	White, e						
rs after ural", miner	ᆰ	3 Widowed 4 X Divorced if Yes, Give Year 1 Yes 2 X No specify: or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Specify: ]						
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		TOD. TAING OF DOOR.	oco, mademy					
036 ithin 7 ane. r than 4edica	힐	l yr. License Practical Nur			on Hosp. Ctr.					
21215-0036 ould be filed within 72 d Mental Hygiene. is event, the Medical.		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	Maiden Surname)						
2121 Ild be f Vental Marke event	To Be	James Render Pecola  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	Dowdle Rural Route Nur	nber. City or Town.	State, Zip Code)					
imore, MD 2 Pages I and 2 shour nent of Health and In and: If ritem 27 is in or other traumatic	7	Erica Morris/Daughter 3406 Metzerott Rd, C								
ore, MD ss I and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - Ci	ty or Town, State					
Pages nent of ant: I		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Norbeck Memorial Park 06 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Mai	-26-2007	Olney,	MD					
Faltimore, emit. Pages I ar epartament of Hec Important. If ten njury or other tr	Ī									
	4	4217 9th Street, 23st Part I. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac			OC 20011 Approximate Interval					
Physician /Medical		failure. List only one cause on each line.	,		Between Onset and Death					
Examiner	-	Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Amerosclerotic Cardiovascular Disease  Due to (or as a consequence of):								
	ᆡ	Sequentially list conditions, b								
	<u> </u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.								
od sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
50, te be executed ysician and burial - transit	ledical	UNPENDED XII COCO 7 /07 /07								
60, ate be hysicia e burit	i g	UNPENDED #44, perME, C869, 7/27/07 TT  IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery					
cath certificate eath certificate attending phy for use as the l	an/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	Month	Day Year					
Box 68760, c death certificate be the attending physic dor use as the burrent of for use as the burrent of the transport of tran	Physician/N	1 Yes 2 ✓ No 9 Unknown 4 Pregnant at time or death 5 Other (Specify) 9 Unknown								
that the de ned by the detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death?					
S, P.O	ed by		1 Ye		Probably 4 V Unknown					
of Vital Records, g Physician: The law require the this certificate has been s meral director, page 2 should it	Completed		24a. Was		re autopsy findings available or to completion of cause of					
Rec The la	팅		1 Yes		Yes 2 No					
Vital Rec	Be	25. Was case referred to medical examiner? Hospital: 1 Incatient 2 ER/Outpatient 3 DOA Other: Nurs		Residence 6 🗸	Othor Coops					
1 of Vi	의	1 Yes 2 No  27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	ing Home 5 28d. Describe	how injury occurred	Other: Scene					
ion c trending leath tor: Af	틹	Natural 5 Pending								
Division tal or Attendi rs after death al Director: A	<u>i</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location ( or Town,		or Rural Route Number, City					
Divis Hospital or At 24 hours after d Funeral Directed filled in by	Certification:	4 Homicide determined (Specify)	or rown,							
0 - 5 5	- 1	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)					
To the within To the To the complet	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number			(Month, Day, Year)					
8		Patrillem POOR O.C.M.E.		June 20, 200	7					
8	-	30. Name and address of person who completed cause of death (Item 23a)								
-7		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 2120	)1 						
Sta Registr		3 JON (2 Go 2007, Year) Selection 32. Registrar's Signature								

		22	For State Registrar	State of Ma	-		artment of F tificate of		ind Me		jiene eg. No.	0.17	22125
	Physici /Medic		Decedent's Name (First, Middle     HARRY	e, Last) JAC	OBS					2. Date of Dea Month JUNE 26	Day	)7 Year	3. Time of Death 3:48 P M
	Examin		4a. Facility Name (If not institution 29685 ALLISON				4b. City, Town, o	or Location o				unty of Death	
- 15 m	Funeral Director		5. Social Security Number 333–14–5422		(In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day FEB • 6 •	1923	9. Birth MICI	place (State or Foreign Intry) HIGAN
To come of the com	a-f show tified at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD ST.	MARY'S	10c. City, Town		cation CSVILLE						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
4	3a or 28 st be no	ai Dire	10e. Street and Number 29685 ALLISON (	CIRCLE			10f. Zîp Code <b>20</b>	659			-	of What Cou <b>A</b>	untry?
d 21215-0036	tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marr 3 ▼Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? ied 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S.		Was Decedent of H f Yes, specify Cub		gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		Race - Amer Black, White pecify:	
15-003	"natur	Completed	15. Deceden (Specify only higher	st grade completed)		Deced (Give life. I	dent's Usual Occup kind of work done OO NOT use retire	oation during most d)	of working	9	16b. Kind	of Business/I	ndustry
212	Hygiene.	Com	Elementary/Secondary (0-12)	College (1-4or 5+	S	ALE	SMAN	10 Mothe	r'a Marra /	(Eirot Middle			PRODUCTS
Maryland	e d al	To Be	17. Father's Name (First, Middle, HARRY	M.	JAC	OBS		MILI		First, Middle,	BAN		
Mary	an is		19a. Informant's Name/Relations	-	1		ng Address (Street				-		
- 6	of Health Fitem 27 r other tr	ŀ	LINDA VALENTINI  20a. Method of Disposition	,			ALLISON sition (Name of matory or other pla		Da			tion - City or 1	
Baltimore,	Department of Important: If any Injury or once.		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	pecify)		iel	d-Echo1s	Cr.	6/28/	2007			ALL, MD
Ba	Depa Impo any I		Journ B		0641	Br 3	2. Name and Address insfield 0195 Thr	-Echo ee No	ls Fu tch R	neral l	lome, arlot	P.A. te Hal	1, MD 20622
je .	hysician hysician and hysician and sthe prival-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hero Due to (or as a b. Due to (or as a c. Due to (or as a d.	consequence of	of):  \ve of):	ic Car			ulari sease		ase	Onset and Death
Records, P.O. Box (		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death		⊒Ectopic pregnanc ]Other <i>(specify)</i> _	y .			230	I. Date of deli Month	very Day Year
JS, P	been signed by the should be detached		Part II. Other significant condition	•	not resulting in		nderlying cause giv	ven in Part I.					the cause of death?
		Completed by	Diabetes	cidney comellitu	Lisea.					24a. Was a autop perfor	an 2	24b. Were au prior to c death?	topsy findings available completion of cause of
r VII	is certificate director, pag	To Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ No	Hoepital:	it 2 ☐ ER/Ou	tpatier	nt 3 DOA Oti	205		( <i>Check only o</i> e 5 ⊾ Resid		☐Other (Spec	cify)
Division or Vita	ector: After the by the funeral	Certification: 1	27. Manner of Death  1 Natural 5 Pendir  2 Accident investi  3 Suicide 6 Could  4 Homicide determ	gation not be 280 Place of initial	Year) li ry - At home, fa	Time o njury rm, str	M 1□	ryat rk? ]Yes 2∏!	No	3d. Describe h  3f. Location (S  City or Tow	treet and N		ral Route Number,
ם יפ	within 24 hours after death.  To the Funeral Director: All completely filled in by the further further forms and the further f	edical Cert	29a. Certifier 1 ☐ Certifyir (Check only 2 ☐ Medical	ng Physician: To the best of Examiner: On the basis of	f my knowledge					nd due to the	cause(s) ar		
P. C.	within 2  To the comple	Med	29b. Signature and title of certific	and manner state	ed.		29c. Licens	se number	653			signed (Month	2007
			30. Name and address of person 5851 - Dec		ath (Item 23a) ( LA +ON		Print) GY Road T	AN	C.	SUR	19 N 19 20	757	
	Sta Regist	_	31. Date filed (Month, Day, Year)	32. Registra	r's Signature								
DHM	H 17 Rev 1/2	001			1								

			For State Registrar	State of Mar	yland		irtmen tificati					giene Reg. No		00	07
			Decedent's Name (First, Middle, Last)							2	2. Date of Dea		4001	8-Time o	Death
	Physicia /Medic		Joe Lee Jordan								JUNE	2	200	7 1142	PM
	Examin		4a. Facility Name (If not institution, give st	reet and number)				_	Location	of Death			County of Dea		
		3.4	Doctor's Hospital  5. Social Security Number 6. Sex	7 400	(In use Inc	t birthday)	Lan If Under		If Under	r 24 Hrs.   8	Date of Birt		rince G	thplace (State	
l a	Funeral Director			M 2□F 77	iii yis. ias	Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Day 15-30-	y, Year) 1930	NC	ountry)	si i oreign
	_		Usual Residence of Decedent												
	h the Maryian r 28a-f show notified at	_	MD Prince GE		-	Town or Loc lover	cation							10d. Inside C	City Limits  2 [X] No
	he Ma 18a-f s otiffie	ecto		orige s	Lano	uvel	104 75-	0-1-				10a Cit	izen of What C		
0)	with th	Funeral Director	10e. Street and Number 1905 bender cowrt				10f. Zip	785				USA		oundy:	
9)	leath w ns 23a must t	eral		2. Was Decedent Ev	er in U.S.	13. V			ispanic O	rigin? (Speci	ify Yes or No- ican, etc.)		14. Race - Am		
7 98	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Fur	1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Yes, spe⊲ □Yes		ın, Mexica Specify		ican, etc.)		Black, Whi	<sub>te, etc.</sub> Lack	
70 C 1	72 hours "natural",	ed b	15. Decedent's Educ	ation	Ţ	16a. Deced	ent's Usua	al Occup	ation			16b. K	ind of Business	/Industry	
2 215	within 72 ho jiene. r than "natui the Medical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)						st of working	'				
	filed withir Hygiene. other than	Com	6th			Park	ing a	<u>tten</u>					gett Po	rking	
JORDAN Baltimore, Maryland	12 should be filed whand Mental Hygie 7 is marked other traumatic event, th	Be	17. Father's Name (First, Middle, Last)  Robert Jordan						18. Moth		First, Middle, 1known	Maider	Surname)		
> \sum_{\overline{N}}	d 2 should the and Menity 7 is marked traumatice	욘	19a. Informant's Name/Relationship (Typ	e. Print)		19b. Mailin	g Address	(Street	and Numl	ber or Rural	Route Numb	er, City	or Town, State,	Zip Code)	
Z Z	a te contraction		Michael Jordan/sov	l		1909	Sarat	oga	Dr	Hyatts	sville,	, $MD$	20783		
CRDAN more, Mary	es 1 and of Healt fitem 2 r other		20a. Method of Disposition 1 A Burial 2 □ Cremation 3 □ Re	amoval from State	20b. Pla	ce of Disponetery, crem	sition (Nar natory or c	ne of ther plac		Da		20c. L	ocation - City o	r Town, State	
E C	Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		На	rmony				06-30-			dover,		_
1 ) <u>Ba</u>	permit. Pages 1 s Department of He Important: If item any injury or oth		21. Signature of Funeral Service License	ansho	10								neral f n, DC 2		ıc
	Č.		23a. Part . Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line	he death.	Do not ent	er the mod	le of dyir	ıg, such a	s cardiac or	respiratory a	rrest,		Approxima Interval Be	ite etween
	Physician		Immediate Cause (Final disease or condition	MYTASTA							cison			Onset and	Deam
	/Medical Examiner		resulting in death)	Due to (or as a	conseque									1	
- 1		-e	Sequentially list conditions, b	Danie to (or ms as	eceseque	nos of):									
	uted	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
o.	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	conseque	ence of):									
8760.	ate be hysici the bu	dical	d											1	
$\omega$	ertifica ling pl	ω .	IF FEMALE:	3c. If yes, outcome p	f prognan	CV				<del></del>			20d Data of d		_
Вох	eath certifi attending p	Physician/M	in the past 12 months?	1□Live birth 2 4□Pregnant at ti	Fetal	leath 3□	Ectopic p		/				23d. Date of d Month	Day	Year
Ö	that the de ed by the dedetached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown											
Division or Vital Records. P.O.	res that igned b	by	Part II. Other significant conditions con	tributing to death but	not result	ing in the ur	nderlying o	ause giv	en in Parl	1.			use contribute 2 ☐ No 3 ☐ I		
0.00	w require been si should b	eted									-		T		-
Bec	The law ate has t	Completed		-								psy ormed?	prior to death?	autopsy findings completion of	cause of
ta	ician; Th certificate ector, pag		25. Was case referred to medical						26. Pla	ce of Death	1□ Yes (Check only o	22 N	0 1 □ Ye	s 2 No	
<u> </u>	ysician; is certific director,	To Be	examiner?	ospital: Inpatien	t 2 🗆 E	R/Outpatier	nt 3□ D0	OA Oth	er: 4 🗆 N	Nursing Hom	ne 5 ☐ Resi	dence	6 □Other (Sp	ecify)	
0	ding Ph		27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		28b. Time of Injury		28c. Injui Wor			Bd. Describe	how inju	ury occurred		
Sio	tendii eath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2		7. L			Don't Books Miss	
DIV	after d after d Direct d in by	Certification:	4 Homicide determined	28e. Place of injur building, etc.	(Specify)	ne, rarm, su	eet, factor	y, office		20	City or To		nd Number or I le)	nurai moute ivu	mber,
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only 2 Medical Examin	ner: On the basis of e	examination	ledge, deat on and/or in	h occurred vestigation	at the ti	me, date opinion, d	and place, a eath occurre	nd due to the	cause( , date a	s) and manner nd place, and d	as stated. ue to the cause	!(s)
	thin 2 the or the or	Medical	29b. Signature and title of certifier	and manner state	ed.		29	c. Licens	e number	,		29d. Di	ate signed (Mo	nth, Day, Year)	
	Naith Con		• 1M 11 X	My			1	727	226	1					
	6		30, Name and address of person who co	mpleted cause of dea	ath (Item 2	23a) (Type.	Print)	/ 7 `	~	•		-	-22-		****
	<b>6</b> 7		0	MAT, M		500		APOL	-11	re,	LANh	91	mo	20706	>
	Sta Begist	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	ire				,					

			1 - State Registrar	Department of Health and M Certificate of Death		ene g. No.? () () 7	22128
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  Isaac A. Jackson  4a. Facility Name (If not institution, give street and number)		2. Date of Death Month June 1	6th 2007	
	Examir Funeral Director		Suburban Hospital  5. Social Security Number  6. Sex 18 M 2 F	4b. City, Town, or Location of Death  Bethesda  thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Feb 17,	4c. County of Dea	thplace (State or Foreign
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location	Feb 17,	1913  Sot	th Carolin
	with the Mi a or 28a-f	Director	DC Washin  10e. Street and Number  3916 7th Street NE	9ton 10f. Zip Code 20017		g. Citizen of What Co	1 Yes 2 XNo
036	be filed within 72 hours after deeth with the Maryland nat lygiene. dother than "natural", or iteme 23a or 28a-1 ehow event, the Modical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☒ No Specify:		14. Race - Ame Black, Whit	e, etc.
Maryland 21215-0036	d within 72 ho giene. or than "natura the Modical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Bementary/Secondary (0-12)  7th  16a.  College (1-4or 5+)  En	Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)  gineer	ng	6b. Kind of Business Private	,
yland		To Be C	17. Father's Name (First, Middle, Last) Chester A. Jackson Sr.	18. Mother's Name Lottie	(First, Middle, M Washir		
	1 end 2 Health a em 27 i		Pearl Jackson (Wife) 39	Mailing Address (Street and Number or Rural  16 7th Street NE V	Washing		20017
Baltimore,	permit. Pages Department of Important: if it any injury or o			y, crematory or other place)			Maryland
			23a. Pan'. Inter the disease, or compiler ions that caused the death. Do not not not not not not not not not no	Tyrone J. Young on the order the mode of dying, such as cardiac or			
i	Physician /Medical Examiner		disease or condition resulting in death)  a Respiratory  Due to (or as a consequence of	distress pneumonia			Years Hours
9/60,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use es the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. ASPITATION  Due to (or as a consequence of the control of				
.O. Box 6	I the death certific by the attending pl ached for use es t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
cords, r	requires that the een signed by th hould be detache	ρχ	Part II. Other significant conditions contributing to death but not resulting in Stroke, Seizures, Clostridium			acco use contribute to ; 2 □ No 3 □ Pr	the cause of death?
200	n: The law r licete has be r, pege 2 sh	Completed	Colitis, Deep venous Thrombos Pervtaneous gasterstomy tube		24a. Was an autopsy perform	24b. Were au prior to death? 1 No 1 Pes	topsy findings avaiłable completion of cause of 2□ No
	Physician: r this certifice ral director,	To Be		26. Place of Death patient 3 DOA Cther: 4 Nursing Hom		ce 6 □Other (Spe	city)
IVISION	of the Mospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:		njury Work?  M 1 □ Yes 2 □ No		eet and Number or Ru	iral Route Number,
ב	To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	Medical Cer	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and or investigation, in my opinion, death occurred	nd due to the cau	sea(s) and manner as	stated. to the cause(s)
92	To th within To th compl		29b. Signature and title of certifier			d. Date signed (Monti	
2	3		30. Name and address of person who completed cause of death (Item 23a) (Arun Anuradha MD 10301 Georgi	a Ave.Suite 209 S	ilver S	pring,Md	20902
	Stat Registra	e	31. Date filed (Month, Day, Year)  JUN 2 6 2007  32. Registrar's Signature of the signature	W		390 H	

#### 07-05110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Nathaniel Ross I		selring 1- For State	State	of Maryla			nent of cate of			Menta	al Hy		No		17 991
Physicia		Registrar 1. Decedent's Name (First, M	ddle,Last	)		-					2	Date of Death	No Day Year	,	3. Time of Death
Medical Exami	ner	Nathanie				ng	- 17	th Oire T		anation of	Dooth	July 4, 200	4c. County o		0358 hrs
d		4a. Facility Name (if not instit Rt. 50 E/B near Ha		e street and nur	nber)		4	Berlin	own, or L	ocation of	Death		Worcest		
Funeral		5. Social Security Number	6. Se	x	7. Age (In	n yrs. last b	irthday)	_	r 1 Year	If Under		8. Date of Birth	(MM/DD/YYYY	g. Birt Foreig	hplace (State or
Director		173-66-5208	1	M 2 F		22	Yrs.	Months	Days	Hours	Min.	05/30,	/1985	· Coi	untry) PA
· settled strong	-	Usual Residence of Decedent 10a, State 10b, Cou			1100	City Tow	vn or Locati	on							10d. Inside City Limits
now an		PA 10b. Cou	•	nklin	100	-	Quinc		vnsh:	ip					1 Yes 2 X No
aryland 8a-f sh at onc	Director	10e. Street and Number					`	10f. Zip	Code			10	g. Citizen of Wh	at Cour	ntry?
215-0036 be filed within 72 hours after death with the Maryland and Hydrogen the Maryland filed within a state of the red other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once,	Dire	6557 Furn	ace	Road						1726	8	22		JSA	
≥ 8 9 1	uneral	11, Marital Status 1 X Never Married 2	Married	12. Was Dece Armed Fo		er in U.S.						cify Yes or No- Rican, etc.)	14. Race White		can Indian, Black,
er deat	ш.	3 Widowed 4		1 Yes If Yes, Give Year	2 X	No	1	Yes 2	X No	specify:			Specify:	Wh	ite
ours aft ntoral'	d by	15. Decedent's Education (		or Dates:		ted) 16	a. Deceden	t's Usual	Occupation	on (Give k			16b. Kind of Bu	siness/	Industry
6 172 hc an "ns ical Ex	lete	Elementary/Secondary (0-	12)	College (1	4 or 5+)			pet		DO NOT	, se reure	(1)	Carpe	t C	
.003 withir giene her th	Completed	17. Father's Name (First, Mic	dle Last)				Cal	-pet			Name (	First, Middle, M			<u> </u>
215- e filed tal Hy ked of	Be C	Keith D. K								Ka	ari	L. Mowe	n		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene rant: If item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner must	Tol	19a. Informant's Name/Relat			e			_				ural Route Numl			
ME 2 Sleath ar		Keith D. K	esse	iring	rat	her	e of Dispos				, wa	ynesbor Date	20c. Location		
Ore ges la t of He : If its		1 X Burial 2 Crem			om State	cren	natory or ot Zion	her place)			07/0	09/2007	Ouinc	v. I	PA.
Baltimore, permit. Pages   ar Department of Hee Important: If ite	7	4 Donation 5 Other 21 Signature of Funeral Ser													al Home, In 17268
Balti permit. Departr Import injury	1 14	Chmos Q	Bu	buse			- 1								
Physician /Medical	9	23a. Fart I. Enter the disease failure. List only one ca	use on ea			e death. Do	not enter t	he mode	of dying,	such as ca	ardiac or	respiratory arre	st, shock, or he	ап	Approximate Interval Between Onset and Death
∄ aminer		or condition resulting in dea		Due to (or as a	consequ	ence of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca	6.	Due to (or as a	consequ	ience of):									
e executed sian and ial - transit	Examine	(Disease or injury that initial events resulting in death) L	ed	Due to (or as a	consequ	ience of):									
	dical	UNPENDED		AMENDED			,						33-53		
68760, certificate b nding physics se as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant	in the	23c. If yes,		of pregnan		etal death	3	Ectopic	pregna	ncv	23d. Date of Month		ry Day Year
lox 687 leath certific e attending	icia	past 12 months?		4 Pregn		ne of death	-	ther (Spe	cify)	•					
Box he death con the attent by the attent hed for us	Phys	1 Yes 2 No 9 Part II. Other significant co		9 Olikik		ut not resu	Iting in the	underlying	i cause o	iven in Pa	rt I.	23e. Did to	bacco use conti	ribute to	the cause of death?
P.O. ss that the gened by		Fart II. Other Significant of	licitions	contributing to	Jueani	at not resu	iting in the	andonym	, caace g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 Yes	2 🗸 No 3	Pro	bably 4 Unknown
n of Vital Records, P.( ing Physician: The law requires that After this certificate has been signed tuneral director, page 2 should be det	Completed								_			24a. Was a			utopsy findings available completion of cause of
e baw te has ge 2 sk	ᄪ	-	-									perfor	med?	death?	
A R. III. The striffice stor, pa	Be C	25. Was case referred to me	-							of Death	(Check o	only one)			
Division of Vital Records, tal or Attending Physician: The law require in Britan chair. The law require in Britan chair. After this certificate has been sifted in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	_ 일 명	examiner?			Inpatient		R/Outpatien			Other <sub>4</sub>		g Home 5	Residence 6		er: Scene
n of ding Ph		27. Manner of Death  1 Natural 5	Pending	Jul 4, 20	of Injury Day,Year		8b. Time of 355 hrs	injury		ryatWork Yes 2 ✔	No.	Occupant a	uto involved	in mo	otor vehicle
ivisior or Attence after death Director:	ertification	2 🗸 Accident	Investigat	28e Plan	e of Injur	y - At home	e, farm, stre	eet, factor	, office b	uilding, et	c.	accident 28f. Location (S	treet and Numb	per or F	Rural Route Number, City
Div ital or urs afte	ertif	3 Suicide 6 Homicide	Could not determine	4	Majo	r Road /	Highwa	у				or Town, S Rt. 50 E/B Ne	tate) ar Hall Road,	Berlin	MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Salc	29a. Certifier	ng Physic	ian: To the be	st of my k	nowledge,	death occu	urred at th	e time, da	ate and pla	ace, and	due to the caus t the time, date	e(s) and manne	er as sta	ated.
To the within To the	Medical			and manner s	or examir	nation and/	or investiga			e number	curred a	- trie time, date			onth, Day, Year)
	2	29b. Signature and title of c	, quei	my				23	O.C.				July 5, 20		
		30. Name and address of pe	rson who	completed cau	se of dea	ath (Item 23	Ba)								
3			istant N	Medical Exa	T		enn Stre			MD 212	201				
S	tate	31. Date filed (Month: Day, )	1 0 2	007 32	egistrar's	Signature	AND	ric							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar per FH/wichd/6-25-07/dls Amend item #8 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4b. City, Town, or Location of Death 06: 20 PM. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Manor Nursing HurrR Sex 7. Age (If yrs. last birthday)
Yrs. Princescame
If Under 1 Year | If Under 24 Hrs. Som MANOKIN Social Security Number Date of Birth 0-8-26 9. Birthplace (State or Foreign (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2□F 80 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic svent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo omerse 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 18 Items 23a 0 TNOT Koa Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 □ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ŏ Maryland 21215-0036 1 Yes 2 No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Black "natural" 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (9-12) College (1-4or 5+) Room th grade ENGINEER College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I Kohor Kenner Cr. CUUC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Lip Code) Konney (daught, Policy (Name of cemetery, crematory or other place) parmit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Marion Ducadaly N 20a. Method of Disposition Baltimore, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) JOhn Canatary 24-0 21. Signature of Frineral Service Licensee 22. Name and Address of Facility /3 10 Isabella 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** na disease or condition resulting in death) gro /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien hed for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2∠No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate er 250 No 21**3** No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 06 - 20 - 2007

Registrar DHMH 17 Rev 1/2001 regers h.

JUN 2 2 2007

31. Date filed (Month, Day, Year)

O. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Mi

D 29505

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

		Registrar		C	Certificat	te of L	Jeath			Reg. No.	2007	2210
D1		1. Decedent's Name (First, Middle, Last	)						2. Date of De Month	ath Day	Year	3. Time of Death
Physicia /Medic	al	Margaret Mae Kersh	ner						JUNE	25	2017	2-11AN
Examin	_	4a. Fecility Name (If not institution, give					Location o	f Death			County of Death Ashingto	
	,	Western Maryland F 5. Social Security Number 6. Se		(In yrs. last birtho		ersto	If Under 2	24 Hrs.	8. Date of Bir			plece (State or Foreig
Funeral Director		216-14-5400	M 27% F	85 Yr	Months	Days	Hours	Min.	Oct 3,	ay, Year)	Cou	intry) vland
and I	-	Usuel Residence of Decedent  10a, State 10b, County	T	10c. City, Town o	or Location							10d. Inside City Limits
Maryland If show	ğ	Maryland Washingto		Hagerst	OTTO							1 Yes 2 □ No
with the 1 3a or 28a-	rec	10e. Street and Number	)11	nageist		p Code				10g. Citiz	en of What Cou	intry?
h witt	by Funeral Director	805 Dale St.			21	1740				Ţ	J.S.A.	
deat deat	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Dece If Yes, spe	edent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	o- 1	4. Race - Amer Black, White	
or It	Y Fu	1 Never Married 2 Married	1 Tes 2 No		1 🗆 Yes		Specify:				Specify:	
ural',	q p	3 XWidowed 4 □ Divorced	Year or Dates:	100 D	ecedent's Usu	un l Oncurre	ation.			16h Kir	What of Business/I	nite
n 72	Completed	15. Decedent's Edu (Specify only highest grad	de completed)	((	Give kind of wo	ork done a	turing most	of work	ing	TOD. KI	id or businesser	ridustry
within ene. than	HO.	Elementary/Secondary (0-12)	College (1-4or 5+		retary					Uı	nion	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  By the Marylan Standard of the relation of the standard of the standard	Be Co	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	e (First, Middle			
Aenta rked tic ev	To B	Hilbert C. Willia	amson				Ju1	Lia l	M. Temp	1on		
should and Men smarke sumatic		19a. Informant's Name/Relationship (T)	ype, Print)	19b. A	Mailing Address	s (Street a	ind Numbe	r or Rur	al Route Numb	er, City or	Town, State, Z	ip Code)
and Saalth n 27 in tra		Carolyn L. Chaney	/ Daughte		in the second		on Ro					ania 17225
of He		20a. Method of Disposition	Removal from State	20b. Place of D cemetery,	Disposition (Na., crematory or o	ame of other place	θ)	Į.	Date	20c. Lo	cation - City or 1	Town, State
Pag ment ant: I ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		Smiths	burg Ci	remat	ory 6	/26	/2007	Smith	sburg N	laryland
Departimport		21. Signal ne of Tuneral Service Licens	9		22. Name a			ILC:			neral Ch	
ZOE = a		mn	1200								own Mary	1and 2174 Approximate
\$		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line	the death. Do no e.	ot enter the mod	ide of avino	g, such as	cardiac (	or respiratory a	trrest,	1	Approximate
Physician /Medical			-min									Interval Between Onset and Death
rincalout		Immediate Cause (Final disease or condition resulting in death)	a	die !	ANCH							
Examiner		disease or condition		consequence of	4 ~~~			-				Onset and Death
Examiner	ier	disease or condition resulting in death)  Sequentially list conditions, if any, leading to an inequate	b. More	die !	+~~~ ):							Onset and Death
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Examiner and I-transit	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to an inequate	b. Cue to for as a	consequence of	1. (2):							Onset and Death
to be executed ysician and be burial-transit	ical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Cue to for as a	a consequence of	1. (2):							Onset and Death
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to be executed ysician and be burial-transit	ical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	b. Use to (or as a d. Due to (or as a d. 23c. If yes, outcome o	a consequence of	A Notes  ):  3□Ectopic p	pregnancy	^-~				23d. Date of deli	Onset and Death
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 96 2001 Timothy Daren Kinslow Junz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) Jan. 20,1976 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days Mary Land **X**XM 2□ F 31 **Director** 214-13-0235 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1X Yes 2 □ No Director Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21740 USA 112 East Avenue Apt. 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★XNo If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Landscaping Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberta Ann Musser ၉ Robert Wendell Kinslow, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta A. Kinslow - Mother 361 Daycotah Ave. Hagerstown, Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 Other (Specify) Cedar Lawn Mem. Park June 30,2007 Hagerstown, Maryland 21. Simature of uneral S OSDEPNE APENEFEITY Home, P.A. 425 S. Conococheague St. Williamsport, Maryland Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1/2 years disease or condition resulting in death) Colon Charce /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause United as Indiany that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 1 TYes 2□ No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Injury 1 Natural 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 TYes 2 TNo death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

03H-4

State Registrar

DHMH 17 Rev 1/2001

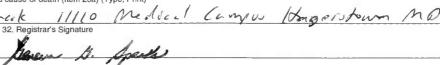
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Corneck

29b. Signature and title of certifier

Michael



29c. License number

29d. Date signed (Month, Day, Year)

6.27.07

			For State Registrar		State	JI IVIA	ryland / De	partme <i>ertifica</i>				ieniai ny	_		
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	/Medic		4a. Facility Name (If no			umber)		4b. Cit	, Town, or	Location	n of Death	June	18	C. County of De	
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	72 hours after death with the Maryland natural", or items 23a or 28a-f show item Examiner must be notified at			5. Decedent's E			16a. De	cedent's Us	ual Occup	ation			16b. l	Kind of Busines	s/Industry
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	or A after d Direction by	Certification:	4 ☐ Homicide	determine			. (Specify)	Sileet, lact	iry, onice			City or To			Rural Route Number,
•	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1	Certifying F	hysician: To the	ne best o	f my knowledge, d	eath occurre	d at the tir	ne, date	and place,	and due to the	e cause(	s) and manner	as stated.
	the Hi in 24 he Fi pletel	edical	(Check only 2[ one)	∟ medical Exa		basis of inner stat						red at the time	e, daté a	nu piace, and c	ue to the cause(s)
		Σ	29b. Signature and titl	le of certifier				2	9c. Licens	e numbe	r		29d. D	ate signed (Mo	nth, Day, Year)
	3								D53	3528			J	une 20,	2007
			30. Name and address												
			Daphna He		32.	<b>S</b> paietra	rgia Avenue r's Signature	_		01ne	y, Mar	yland 20	832		
	Sta Registr			N 2 5 2	007	Ugistia	J. J.	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 28f per me, g870, 08/02/07dbb
Reg. No.
Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last, Day 2. Date of Death Month **Physician** 2007 une /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner washingtor Hagerstown Washington County **Hospital** If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Sex 1M M 2□F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Director 60 2/30/1946 207-38-2000 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show Iner must be notified at 1 X Yes 2 □ No Director PA Washington Erie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11051 Rt.99 16426 by Funeral USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1XX7es 2 ☐ No If Yes, Give 11. Marital Status th and Mental Hygiene. It is marked other than "natural", or Item traumatic event, the Medical Examiner I Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virgil H. Knickerbocker Lucille VanDusen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Kimberly Peterson/Daughter 112 Eagles Ridge, Smithsburg, Md. 21783 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State McLane Cemetery 6/29/2007 McLane, Pa. 16412 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Glunt Funeral Home, Inc. 21. Signature of Funeral Service Lig . floelke #M01035 210 Erie Street Edinboro, Pa. 16412 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Nachani /Medical as a consequence of): Examiner bdula quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner EXAMPLER The law requires that the death certificate be executed burial-transi CERTIFICATION APPROVED Due to (or as a consequence of): Box 68760 Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No 9☐Unknown Division or Vital Records, P.O. 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner?
1 XYes 2 No the funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury
(Mpnth, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at After To the Hospital or Attending 5 Pending investigation 1 Natural 6/16/0 after death. all, Stajv Case 1 Yes 2 No Accident 28e. Place of njury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11051 Pt. 00 determined 4 Homicide Mckean, PA 16421 Rt 99 Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical UZ 29c. Webse Kumbo within 2 To the 29b. Sign 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JH-10+1

31. Date filed (Month, Day,

JUN 2 9 2007

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:13 P M 23 2007 June Pearl Opal Lyall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Manor Healthcare Center Rising Sun Ceci1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🗓 F Sept. 10, 1914 North Carolina 220-14-2149 Director 92 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Rising Sun Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21911 1881 Telegraph Road Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Goodman George Long မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1945 Colora Road, Colora, MD 21917 Joan Hicks/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Conowingo Bapt. Cem. 6-26-2007 Conowingo, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
R. T. Foard Funeral Home, P.
111 S. Queen Street, Rising 21. Signature of Funeral Service License Pakt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ence of) (or as a conse Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): or Vital Records, P.O. Box 68760, physician Physician/Medical the attending I for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Hunknown Completed peen Were autopsy findings available prior to completion of cause of death?

1 Yes 2 46 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2[4 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Funeral Director; After completely filled in by the funera Division To the Hospital or Attending 5 Pending investigation 2 🗌 No 1 Tes death. 2 Accident 6 ☐ Could no be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide detern 4 Homicide within 24 hours after certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 34 31. Date filed (Month, Day, Year) State JUN 2 6 2007 Registrar

			1 - For Stata Registrar		epartment of Health and M Certificate of Death		ene g. No 0 0 7	22137
п	Physic	an	1. Decedent's Name (First, Middle, Last	")		2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Ronald	Lee	Loveless	June	26, 2007	<sup>7</sup> 2123 <sup>M</sup>
E	Examir	ner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Dea	
			12131 Heather Dri		Hagerstown		Washing	
	Funeral Director		217-42-9819	TH OTHER	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Oct. 1,	<sup>9. Bir</sup> 1944 Ma	thplace (State or Foreign ountry) aryland
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Mary	ō	Marriland Hashina					1 ☐ Yes 2 🛣 No
	28a	Funeral Director	Maryland Washing	Lon nager	Stown 10f. Zip Code	100	g. Citizen of What Co	puntry?
	3a or		12121 Hoothom Don		21740		USA	,
	death ms 2	Jere	12131 Heather Dr:	12. Was Decedent Ever in U.S.		ecify Yes or No-	14. Race - Ame	erican Indian,
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show odical Examinating the notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 XDivorced	Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 No Specify:</li> </ol>	Rican, etc.)	Black, White	te, etc.
21215-0036	2 hou	ed	15. Decedent's Edu		Decedent's Usual Occupation	1 10	6b. Kind of Business	nite Andustry
75	n n	plet	(Specify only highest grad	le completed) (	Give kind of work done during most of work life. DO NOT use retired)	king	05. ((110 01 50311 033	, madatry
21	d within giene. or then	Completed	11	College (1-4or 5+)	ard Foreman	9	Steel Indu	istry
P	be filed ital Hygi d other event, i	Bec	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
Maryland	D 2 2 0	70	Harry Edward Love	eless	Mildred	Virginia	a Rohrbach	1
an	2 sho and I is ma		19a. Informant's Name/Relationship (T)	rpe, Print) 19b. I	Mailing Address (Street and Number or Rur			
	s 1 and 2 shou f Health and M item 27 is mar other traumati		Carolyn Coulter,	Friend 121	.31 Heather Drive, H	agerstown	n, Md. 217	40
altimore,	00		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ F		Disposition (Name of crematory or other place)	Date 20	Oc. Location - City or	Town, State
Ë	Pagent:		4 □Donation 5 □Other (Specify)	Smiths	burg Crematory 6/28	3/2007 S	mithsburg	, Maryland
Balt	permit. Departmitmportal		21. Signature of Funeral Service Licens	99	22. Name and Address of Facility Re	est Haven	Funeral	Chapel
1.4.1	40 E 9 9		S.Nauc Ju	7	1601 Pennsylvania A			, Md. 21742
			23a. Part1. Enter the disease, or complete shock, or heart failure. List only or complete shock.	ications that caused the death. Do no ne gause on each line.	t enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	- Ameli	chillosty	Innal	none	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	):	OV		
		<u>_</u>	Sequentially list conditions,	o. Due to (or as a consequence of				
	ted nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Los to for as a consequence of				
	rate be executed thysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of				
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687	ficate physis the							
Вох	death certifica e attending phi d for use as th	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of del	inverv
m	death e atte d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
P.O.	w requires that the death certific. been signed by the attending pl should be detached for use as t	Physician/Med	9 Unknown	9□ Unknown				
	law requires that the as been signed by the 2 should be detached	by P	Part II. Other significant conditions con	ntributing to death but not resulting in t	hejunderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Ď	aquire an siç ould t	ed	Chara and	Cr-leng C	Uriese	1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Onknown
သွ	e law re has be ge 2 sho	plet	( indersta	de bleert 1	-ailure	24a. Was an	24b. Were au	itopsy findings available
Ě	The ste h	Completed	Y			autopsy performe 1 ☐ Yes 2	prior to death?	completion of cause of
ita	Attending Physician: The Ir death. ector: After this certificate hay the funeral director, page	Be	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	110 1103	20110
<u>~</u>	Physic this ce al dire	٥	1 Yes 2 No		atient 3 DOA Other: 4 Nursing Ho	me 5 🔀 Residenc	ce 6 □Other (Spe	cify)
D C	Ing P		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury 28b. Tin (Month, Day Year) Inju		28d. Describe how	injury occurred	
<u>s</u>	tend leath tor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No			
Division of Vital Records,	al or At s after o	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Aller th completely filled in by the funeral	Medical (	29a. Certifier 12 Certifying Physical Check only one)	sician: To the best of my knowledge, oner: On the basis of examination and/sand manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cau	se(s) and manner as and place, and due	s stated. to the cause(s)
	of the complete of the complet	Me	29b. Signature and title of certifier		29c. License number	290	f. Date signed (Monti	h, Day, Year)
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•			30 N and address of person who co	mpleted cause of eath (Item 23a) (T)	(pe. Print)		une c	1 6007
SH	IVET		Fredry L	L KASSTI	m/ 11111 h	deel (	Camul	8 0
	Sta	191	31. Date filed (Month, Day, Year)	32. Regetrar's Signature	, CO VY	11	1	
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				OB	IGINAL	•	. (	21242

	1- State of Maryland	Department of He Certificate of D		eg. No. 20138
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year 3. Time of Death 4: 22am
/Medical Examiner	Marie Eleanor Lucabaugh  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L		4c. County of Death
Ladilliloi	1021 Sextant Ct.	Annapol:		Anne Arundel
Funeral Director	5. Social Security Number  184-20-5439  6. Sex 1 □ M XXF  7. Age (In yrs. last		If Under 24 Hrs.   8. Date of Birth   Hours   Min.   6/28/.	9. Birthplace (State or Foreign
/land ow at	Usual Residence of Decedent  10a. State 10b. County 10c. City, T	own or Location		10d. Inside City Limits
e Mary taffed t	MD Anne Arundel Ann	napolis		1 □Yes 🍇 No
with the Mar a or 28a-f st be notified Director	10e. Street and Number	10f. Zip Code	1	l0g. Citizen of What Country?
fter death v r items 23a niner must Funeral	1021 Sextant Ct.  11. Marital Status  12. Was Decedent Ever in U.S.	21401 13. Was Decedent of Hisp	panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian,
Jy Sam Sam Sam Sam Sam Sam Sam Sam Sam Sam	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		, Mexican, Puerto Rican, etc.)  Specify:	Black, White, etc.  Specify: White
72 ho 72 ho inatur dical	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupati (Give kind of work done dur life. DO NOT use retired)	ion ring most of working	16b. Kind of Business/Industry
c I C I D-U( cd within 72 hou ygiene.  ber than "natura t, the Medical E  Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Secretary		Westinghouse
be filed tal Hygi d other event, t		· · · · · · · · · · · · · · · · · · ·	8. Mother's Name (First, Middle,	
yidi bould bo Menta arked atic ev	Lakue Ebernart Glosser		Lillian Grace (	
and 2 sh and 2 sh salth and 127 is m er traum	19a. Informant's Name/Relationship (Type. Print) David W. Lucabaugh Husband		d Number or Rural Route Number Ct. Annapolis, N	
ges 1 If of He or oth	1 Surial 2 ☐ Cremation 3 ☐ Removal from State	e of Disposition (Name of etery, crematory or other place)		20c. Location - City or Town, State
artificor mit. Pages partment of portant: If it y Injury or c	4 □ Donation 5 □ Other (Specify) Lake1  21. Signature of Euperal Service Ligensee	mont Cemetery		Davidsonville, MD uneral Home, P.A.
Deperment once any learning once once once once once once once once	Vooly all	12 Ridgely	Ave. Annapolis	, MD 21401
K .	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying,	such as cardiac or respiratory arr	rest, Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)  a. Due to (or as a consequen	c Tyry/M	1CA	
Examiner				
ed sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ce of):		
executed in and rial-transit	that initiated events resulting in death) Last C Due to (or as a consequen	ce of):		
ficate be executed ficate be executed physician and is the burial-transit edical Examir			·	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.  Medical Certification: To Be Completed by Physician/Medical Examir		eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
res that i igned by be detail		ng in the underlying cause given	in Part I. 23e. Did to	bacco use contribute to the cause of death?
w requires the second of the s			1 U Y	es 2 No 3 Probably 4 Unknown
The law required has been sugged as the control of			24a. Was a autop:	sy prior to completion of cause of
n: The licate   Con				2 No 1 ☐ Yes 2 ☐ No
hysician this certification at director To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2☐ Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3 DOA Other:	26. Place of Death (Check only or	
ing Phy Witter thi uneral o		Bb. Time of linjury a Work?	at 28d. Describe h	ow injury occurred
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Compl	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)		es 2 No  28f. Location (S City or Tow	treet and Number or Rural Route Number,
spital or ours afte neral Di filled in		edge, death occurred at the time		
the Hosp thin 24 hou the Fune impletely fi	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, in my opi	inion, death occurred at the time, o	date and place, and due to the cause(s)
To the within complete the transfer of the tra	29b. Signature and title of certifier	29c. License r	number 2	29d. Date signed (Month, Day, Year)
00	30. Name and address of person who completed cause of death (Item 23	Ba) (Type, Print)  AUP	Ste 231 Anni	aprils was slive
State	31. Date filed (Month, Day, Year)  32. Registrar's Signature	• J	010-0111111	1010 21701
Registrar DHMH 17 Rev 1/2001	JUN 2 2 2007	A speck	_	
		ORIGINAL		

Phy: /M Exa

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1	For State Registrar						Certifi	icate of	Death	,		Reg. N	lo. 2 f	1117	2:	213
1	I. Decedent's Name	First, Middle	, Last)								2. Date of De	ath			3. Tim	e of Death
		Jabez A	vodele	Lano1	ev						Month June		ay .0	Year 2007	1	.:05 aN
4	la. Facility Name (If						4b	. City, Town, o	or Location	of Death				y of Death		
Г	,	y Cross			,			Silv	er Spri	ing			M	lontgom	ery	
5	. Social Security N		6. Sex	7. /	Age (In yrs	s. last birtl		Under 1 Year			8. Date of Bir (Month, Da	th Vea	r)	9. Birthp	place (Sta	te or Forei
	219-37-433	33	1⊠M 2	□F	64	Υ	rs.	onths Days	Hours	Min.	March 18					t Afri
-	Jsual Residence of				1											
1	I0a. State	10b. County			100.0	ity, Town	or Location	on								e City Limit ∕es 2 <b>:</b> ∑N
⊢	Maryland		omery						ilver S	Spring						
1	l 0e. Street and Nur	nber					1	0f. Zip Code				10g. C	Citizen of	What Cour		
L	9900 <b>G</b> eo	orgia Ave							20902				T	U.S.A		
1	11. Marital Status		Arn	ned Force		U.S.	13. Was	Decedent of I s, specify Cub	Hispanic Or oan, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	)-		ice - Americ ack, White,		١,
	1 Never Marri		lf Y	]Yes 2 <u>f</u> es, Give			10	Yes 2⊠ No	Specify.	r:			Speci	ify:	D.1 1 .	
	3 Widowed			ar or Date:	S:	10.	D					106	V: 6 F		Black	
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State Registrar

31. Date filed (Month, Day, Year) JUN 2 2 2007

Maria Jeraldine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tayag,

M.D.



10

D63579

June 12, 2007

20910

1500 Forest Glen Road, Silver Spring, MD

			For State Registrar		-	Certificate of		/lental Hy	Reg. No	007	22140
			1. Decedent's Name (First, Midd	le, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Eugene Peter	Lally				June 2		2007	7:50 PM
	Examir		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	Location of Death		4c. C	County of Death	
			Holy Cross Hos	spital		Silver S	oring		I.	ontgome	ery
notice of	Funeral		5. Social Security Number		e (In yrs. last birtl	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birth	place (State or Foreign ntry)
	Director		078-18-6919	11 M 2 F	82 <sup>Y</sup>	rs.	110010	Jan. 2			w York
	pu ,		Usual Residence of Decedent		10c. City, Town	or Leastion					10d. Inside City Limits
	show dat	_	10a. State 10b. County	/	Toc. City, Town	or Location					1 ☐Yes 2 ☑ No
	Ba-f s	Director	Maryland Mon	tgomery	Olr						
	or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	ntry?
	23a ust t	rai	17613 Georgia			20832				JSA	
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		<ol> <li>Was Decedent of F If Yes, specify Cub.</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No o Rican, etc.)	)- 14	<ol> <li>Race - Ameri Black, White</li> </ol>	
9	or if	y F	1 Never Married 2 Ma	If Yes, Give	No	1 ☐ Yes 2√⊋ No	Specify:			Specify:	
ğ	ural"	d by	3 ☐ Widowed 4 ☐ Divorce		1943-46	Dana dan da Harral Oncorn			16h Kin	Whit	
21215-0036	"nat	Completed	15. Decede (Specify only high	nt's Education est grade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of worl	king		d of Business/Ir	-
7	vithir sne. than	п	Elementary/Secondary (0-12)	College (1-4or 5	5+)		,				vernment
N	Hygie Hygie Her	ပိ	12 17. Father's Name ( <i>First, Middle</i>	/ act)	00	omputer Ana	18. Mother's Nam	ne (First, Middle		ation Surname)	
ŭ	ntal h	Be	Joseph F.				Bridget	,		,	
Maryland	should be filed within 72 hours after death with the Marylan and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	မ	19a. Informant's Name/Relation		10h	Mailing Address (Street					in Coda)
<u>a</u>	ages 1 and 2 should bent of Health and Ment t: If item 27 is marked y or other traumatic e		19a. Illioilliant's Name/nelation	stilp (Type, Film)	190.	Mailing Address (Offeet	and Number of Hu	rai riodie ivanio	ei, Oily Oi	Town, State, 21	p Oode)
	1 and Healt		Rose Marie La	lly/ Wife		7613 Georgia		Olney,		20832 ation - City or T	own State
Ö	Pages nent of B int: If ite		1 ☐ Burial 2 ☐ Cremation	3 □Removal from State		Disposition (Name of r, crematory or other pla	, 0 0	ne 25	200. 200	anon ony or i	om, oato
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Baltimore,	permit. Page Department Important: If any injury or once,		21. Signatury of Juneral Service	Licensee	es	Francis J	. Collins	Funera	1 Hom	ne Inc.	
	@		moll	en tol	2					er Sprin	ng, MD 20901
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	Physician		Immediate Cause (Final disease or condition	Respi	ratory E	ailure					Onoot and Boam
	/Medical		resulting in death)		a consequence o						
	Examiner		Sequentially list conditions,			Chronic Obs	tructive	Pulmona	ry Di	sease	
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	ecute nd trans	am	that initiated events	с							
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-6		an/Me	IF FEMALE: 23b. Was decedent pregnant	d	pf pregnancy	3□Ectopicpregnanc	v		23	3d. Date of deliv	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Doris June Lynch /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5960 Ketch Road Prince Frederick 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F Director 78 168-22-1549 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Prince Frederick MDCalvert County 10e. Street and Number 5960 Ketch Road 20678 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours afternand Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 17. Father's Name (First, Middle, Last) Be Alvin Mathias ဥ 19a. Informant's Name/Relationship (Type. Print)

(Son)

Day June 18, 2007 4c. County of Death Calvert County Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 26. 1928 Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Credit Union 18. Mother's Name (First, Middle, Maiden Surname) Oleva Sargent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5960 Ketch Road, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June  $^{^{\mathrm{Date}}}$  25. Maryland Vets. Cem. 2007 Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once.

Examiner The law requires that the death certificate be executed

attending physician and for use as the burial-tran been signed by the a should be detached the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, I

Physician/Medical

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Completed

Be

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Certification:

Medical

Division or Vital Records, P.O. Box 68760

23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused the death. Do not enter the mode of dying, such as cardiac or nly one cause on each line.	respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	_a Respiration Fallune		Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a)consequence of):  Due to (or as a consequence of):	<b>e</b>	everal yearns
Cause (Disease or injury that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of deliv	very Day Year
Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?

Part II. Other significant con 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

	<u> </u>	$\rightarrow$		
9b.			itle of certifier	
		0		morro

Fred F. Lynch, Jr.

Michael W. Lee

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Bervice Lig

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

20a. Method of Disposition

29c. License number 0 00 2 7 1 8 9

29d. Date signed (Month, Day, Year) 18 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 2 2 2007

2417 Solomons island Rd - Huntingtown, MD 20639 Yousaf, M.D. 31. Date filed (Month, Day, Year) 32. Registra Signature

Registrar

M(

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Lvles Teresa 2007 1045 June 18 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral Months Days Hours Min. 1 □ M 2 🔀 46 DC 216-80-7284 11/27/ Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Counfy show ns 23a or 28a-f shov must be notified at 1 XYes 2 No Md Montgomery Germantown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #3 12909 Churchhill Ridge Circle 20874 USA Funeral death \ 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Black ō 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 2years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic even Francis E. Powell Jr. Carolyn Washington ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ayisha V. Ellis 10700 Donovan Court Gaithersburg Md.20879 Item 27 other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or otl Silver Spring Md. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem 06/25/07 4 ☐ Donation 5 ☐ Other (Specify 21. Signature Funeral Service Licenses 22. Name and Address of Facility 20011 Tyrone J. Young 719 Kennedy St. NW WashDC 23a. Part1. Enter the disease, or complete shock or heart failure. List only of immediate cause (Final used the death onot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Cardiogenic Shock disease or condition resulting in death) 10 days /Medical Due to (or as a consequence of) Examiner 16 days Sepsis Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed days Pneumonia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician 10 days Physician/Medical Failure acute respiratory attending | 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Severe cardiomyopathy Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an Mellitus Diabetes autopsy performed 1□ Yes 2 No Hypertension 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Injury 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined filled in by 4 Homicide within 24 hours a To the Funeral [ Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 41162 June 18th 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctor's Drive Germantown Maryland 20874 Ganti M.D. 31. Date filed (Month, Day, Year) State JUN 2 6 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** July 8:26A M Kendra Α. Mason /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital <u>Clinton</u> <u>Prince</u> Georges 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 👿 F 213-08-3653 38 NC Director Oct.4,1968 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show is marked other than "natural", or Items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Md. PG Suitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2014 Gaylord Drive 20746 United States permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the Medical Examiner must Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Certified Nursing Assistant Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oglesby Andrew Mason Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2014 Gaylord Drive Suitland, Md. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 19a. Informant's Name/Relationship (Type. Print) Frances Chapman/mother 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 7/9/07 Suitland, Md. Cedar Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MY OCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ARTERY CORONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) led by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown s een signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No CARDIO MYOPATHY 24a. Was an DILATED autopsy performed Yes 2 No has 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA r this 27. Manner of Death 1 Matural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: completely filled in by the funeral director, after death. within 24 hours a To the

Baltimore, Maryland 21215-0036

29a, Certifier

(Check only one) 29b. Signature and title of certifier

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D40324

JULY 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503 SURRATTS TERRY JODRIC, MD

ROAD, CLINTON, MARYLAND 20735

State Registrar

31. Date filed (Month, Day, Year)

JUL 1 0 2007



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Fime of Death Physician Month Day 07 03 2007 М 2045 MARGARET MILLS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month Day, Year) Apr 5, 1960 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 M 2 F 213-72-4248 47 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at Rawlings MD Allegany 1 ☐ Yes 🔏 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21557 USA 20713 McMullen Hwy. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married Ž☐ Married 1 Yes 2 No 3altimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event James G. Muir Betty Bogus Muir ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 20713 McMullen Hwy. Rawlings MD 21557 Roger Mills husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Waxler Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 7/7/2007 MD Rawlings 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuheral Service Licensee 22. Name Sand Address Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death An1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immedi e Cause (Final disease or condition resulting in death) **Physician** DIABETTO UNKNOWN/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 □ Yes 21 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an as s certificate ha autopsy 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No ပ 1 Unpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

WA To the Hospital or Attending Physlclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral D completely filled i

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

2007 0 1

W.

Registrar's Signature

29c. License number

900 Soton Drive, Cumberland, MD, a150a

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Paul 6:57 AM 2007 Martin Millham June 23 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore University of Maryland Medical Center NIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X M 2□F Director 06/14/1934 177-26-8888 Pennsylvania Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 40599 Port\_Place 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor Engineering Technology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Edmund L. Millham Mary S. Pachtmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhodessa L. Millham/Wife 40599 Port Place, Leonardtown, MD 20650 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Brinsfield-Echols Cre 06/27/2007 | Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 21. Signature Puneral Service Internee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia clays Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Myocardial Infarction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 NUnknown Completed Be Certification: To

									24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
25. Was case refer	red to medical						26. P	lace of Death	(Check only one)		
examiner? 1 ☐ Yes 2 📉	No	Hospital	l: 1 1 Inpatient	2 ER/Outpatient	3□	DOA	Other: 4	Nursing Hon	ne 5 Residence 6	□Other (Specify)	
27. Manner of Deat 1 Natural 2 Accident	5 ☐ Pending investigation	1	. Date of Injury (Month, Day Ye	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes		8d. Describe how injury		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e	Place of injury - building, etc. (S	At home, farm, stre Specify)	et, fact	ory, of	ffice	2	8f. Location (Street and City or Town, State)	l Number or Rural Route Number,	
29a. Certifier	1 Certifying Ph	ysician:	To the best of m	y knowledge, death	occurr	ed at t	he time, dat	te and place, a	and due to the cause(s)	and manner as stated.	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19840 June 23, 2007

Muce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 2

South Greene Street, Baltimore, MD 21201 1-ena 31. Date filed (Month

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 15425 PAUL WEBSTER *200* MILES, /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital albo Memorial Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1XM 2□F 218-26-1602 80 Yrs JUNE 30,1926 Director MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No **QUEEN ANNE** CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23a or 1552 GRANGE HALL ROAD 21617 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Interportant: If itam 27 is marked other than "natural", or Itel Important: If itam 27 is marked other than "natural", or Itel any july or other traumatic event, the Mudical Exams and SING. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) QUEEN ANNE'S Elementary/Secondary (0-12) College (1-4or 5+) 11 -0-**FOREMAN** COUNTY ROADS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANK GEORGE MILES HATTIE McMOLLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY EVELYN MILES/ WIFE 1552 GRANGE HALL ROAD, CENTREVILLE, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State CHESTERFIELD CEMETERY JULY 2,2007 CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the Geasse or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximated the line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Renax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events physician and the burial-tr resulting in death) Last Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Hospital or Attending Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ro the 29b. Signature and title of certifier 29c. License number 2 32. Registraris Signature

DHMH 17 Rev 1/2001

Registrar

JUN 2 9

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records.

Division of Vital

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zuels

32. Registrar's Signature

1

JUN 27

percisio

31. Date filed (Month, Day, Year)

Wasnington

			_ FOI	partment of Health and N	Mental Hygie	ene	
			State Registrar	Certificate of Death		. No. 9 0 7	22110
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3Time of Death ∪
	/Medic	al	Richard Buchanan Morrisey	4h City Town or Location of Dooth	JUNE	25, 2007 4c. County of Death	′ 05:22F <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death		Balt	imore
	Funeral	3	5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cou	place (State or Foreign ntry)
Н	Director		152-09-3627   15   15   15   15   15   15   15   1	5.	June 29	1918 Nev	Jersey
	land ow		10a. State 10b. County 10c. City, Town C	r Location			10d. Inside City Limits
	Man, a-f sh ified	ķ	Maryland Washington S	mithsburg			1 □Yes 2X No
	or 28.	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	ath w		14240 Windy Haven Road	21783		U.S.A	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 ☑ Never Married 2 □ Married  1 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerting 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify:	
Ğ	72 hou natura lical E	sted	15. Decedent's Education 16a. D (Specify only highest grade completed) ((	ecedent's Usual Occupation Give kind of work done during most of wor	kina 16	b. Kind of Business/Ir	ndustry
21	ithin ne. han "l	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	Give kind of work done during most of wor fe. DO NOT use retired) Section Superviso		Truck Mfc	f.
2	filed w Hygie ther ti nt, th		12 17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
Maryland 21215-0036	0 = 0 6	To Be	Frank Morrisey	Cla	ra Buchan	an Morrise	eV
ary	shou and M s mar	-8		failing Address (Street and Number or Ru			
Ž	and 2 salth a 127 is er tra			240 Windy Haven Roa			
Baltimore,	jes 1 t of He If iten or oth	1 2		isposition (Name of crematory or other place)		c. Location - City or T	
Ē.	t. Pag tment tant: ijury o	- 4	4 □Donation 5 □ Other (Specify) R111990			Ringgold M	
Bai	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility DC 1331 Estern Blvd.	N. Hagers	town Maryl	and 21742
Н			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				
	Examiner		Due to (or as a consequence of)  ACUTE MYOCARI				
		ē	Se yentfally list conditions b.				<del></del>
	cuted id ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	RY DISEASE			
Ö,	e exerian ar		resulting in death) Last Due to (or as a consequence of				
8760,	ficate be executed physician and is the burial-transit	dical	RESPIRATORY F	HILUKE	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burlal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delin	very Day Year
Δ.	s that ned by e deta		Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires been signe should be	ed b	RENAL INSUFFICIENCY		1 ☐ Yes	2□ No 3□ Pro	bably 4 Unknown
Division or Vital Records,	tending Physician: The law re leath. tor: After this certificate has bee the funeral director, page 2 sho	Completed by			24a. Was an autopsy performe 1∐ Yes 2	prior to c death?	opsy findings available ompletion of cause of
Vita	Attending Physician: r death. ector: After this certifics by the funeral director, I	Be	25. Was case referred to medical examiner?  Hospital:	Othory	ath (Check only one)		
or	Physic this crall direct	٦.	1  Yes 2  No		lome 5 ☐ Residen	ce 6 Other (Spec	ify)
on	ding th. After	tion	1 Matural 5 □ Pending (Month, Day Year) Inji 2 □ Accident investigation		200. Describe non	injury occurred	
Divisi	500>	Certification:	3 Sulcide 6 Could not be determined 28e. Place of injury - At home, farn building, etc. (Specify)	a, street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.				
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	, Day, Year)
)			Michael Luthicum	D31826		6-2	0-07
d	4-10+1		30. Name and address of person who completed cause of death (Item 23a) (T				
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11 OSLER DRIVE T	OMSON. M	IARYLAND	21204
	Regist		JUN 28 2007 Jane 1.	South			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Mjddle, Last) Physician [211 M MEALEY EARL 06 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 2/28/1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1□M 200 F 85 422-10-7954 Alabama Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dieal Examiner must be notified at 1 ☐ Yes XX No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 USA 1101 Rivercresent Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc within 72 hours after 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2KNo Specify: þ 3 Vidowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 12 should be filed w h and Mental Hygiel 7 is marked other th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Taylor Acton Callaway Myrtle Swinford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19970 Patricia Phillips 172 Willow Oak Ave. Oceanview, DE Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition ₩¥Burial 2 Cremation 3 Removal from State 6/25/2007 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Dur al Service Lio Owt 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freat failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) + EMURATAGE **Physician** /Medical Due to (or as a consequence of): Examiner Rein Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 3 ☐ Ectopic pregnancy for 1 Month 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 21 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA e Hospital or Attending Ph 24 hours after death. e Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 T Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

the

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 2 2007

29b. Signature and title of pertific

who completed cause of death (Item 23a) Type, Print)

JOHN THE WAY THE BETT HE HAVE ANNAPOLIS MORIFUL egistrar's Signature 32.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Elizabeth Morris 8:38 PM 19/ 06/ 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince Georges' Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2□ F Director 577-74-0377 09/10/1952 N. Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐Yes 2 ☐ No Director MD PG Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ital Hygiene. od other than "natural", or items 23a or ? event, the Medical Examiner must be n 7602 Swan Terrace 20785 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Black 2 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer D. C. Government

18. Mother's Name (First, Middle, Maiden Surname) 2 vears permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be George Miller Dorothy Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7812 Hanover Pkwy #203; Greenbelt, MD 20770 Roman Morris - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 06/30/2007 Brentwood, Maryland 22. Name and Address of Facility
Freeman Funeral Services 2MSignature of Funeral Service Licensee 4594 Beech Road; Temple Hills, MD 20748 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertension /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: asn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) as been signed by the a 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by History of Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ 6 nknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has irector, page 2 2 **☐ N**o 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Division or Vital Records. P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

> 10 By

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

State Registrar

mpleted cause of death (Item 23a) (Type, Print)

Capital

North

1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examilner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WD 21240

Street, NE; Washington, D.C.

29d. Date signed (Month, Day, Year)

20002

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Moor George Edward 4a. Facility Name (Mot institution, give street and number) une 2007 20 /Medical Prince 4b. City, Town, or Location of Death **Examiner** Southern Clinton Inder 1 Year If Under 24 Hrs. HOSPITAL 7. Age (In yrs. last birthday) Maryland If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 X M 2□ F 0013 70 Dec 22 23146 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any liviny or other traumatic event, the Medical Examiner must he market have market once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number US> 20002 St. NE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Aves 2 No 179s, Give Year or Dates: U.A. K.O.O.W. 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 à 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) stod an 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ပ္ ene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20002 Yarker Martha Dau. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 3 ☐ Removal from State 5 Other (Specify) 21. Signature Funeral Service licer DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final disease or condition resulting in death) Physician 5001.1 Unknow /Medical Due to or as a consequence of): Examiner Stau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours are: \_\_\_\_ To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1243446 6.21.27 AR M.D.

Registrar
DHMH 17 Rev 1/2001

State

ROINTAN

31. Date filed (Month, Day, Year)

JUN 2 6 200

Georgia Are Suit 3-41 Silver Spring

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

FARAHIFAR

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

				Otato or maryia		Certificate of		_	Reg. No.	A from Street	1 0 5-
			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time o	f Death
	Physicia		Joseph	Alm raine	-	1000	$\sim$	Month	Day	Year	200
}	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	J	1	4b. City, Town, or			of Death	<b>4.1.</b>
				are Cox	It s	1	eximite	on fairly	2 St.	Mary!	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs		Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Birthplace (State of Country)	or Foreign
-	Director		216-30-4509 Usual Residence of Decedent	73	}	Yrs.		05/19/	1934	Maryland	
	and and		10a. State 10b. County	10c. C	ity, Towr	or Location				10d. Inside C	ity Limits
	Mary f sho	ō	Maryland St. Mary	Mos	hani	csville				1 □ Yes	2 <b>∑</b> No
	1 the	Director	10e. Street and Number	s nec	.IIaIII	10f. Zip Code			10g. Citizen of V	What Country?	
	h with	al D	26400 Laurel Grove	Road		20659			United	States	
	deat	Funeral		12. Was Decedent Ever in L Armed Forces?	J,S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No		e - American Indian, ck, White, etc.	
2	or it	y Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🕅 No If Yes, Give			Specify:	,	Specify		
21215-0020	should be filed within 72 hours after death with the Maryland rand Mental Hygiene. Ind Mental Hygiene. Inarked other then "neturel", or items 23a or 28e4 show umatic event, the Medical Examiner must be mailfied at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	1					Black	
7	n 72 "net	Be Completed	15. Decedent's Edu (Specify only highest grade	completed)	16a.	Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired	ation during most of wo	rking	16b. Kind of Bi	usiness/Industry	
72	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		struction W			Constru	etion	
덛	Hyg other ent,	e C	17. Father's Name (First, Middle, Last)		1001	iscraceron w		me (First, Middle,			
<u>/a</u>	Aenta Aenta rked ric ev	To B	Benjamin Nelson			To the second	Rosalie	Short			
Maryland	2 sho and N is ma		19a. Informant's Name/Relationship (Ty	oe, Print)	19b.	Mailing Address (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip Code)	
≥ .	and 2 salth n 27 i		James L. Nelson, S			981 Lawrenc		Mechan			59
ore	Pages 1 nent of He nnt: If iten iry or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐R	20b. emoval from State	Place of cemeter	Disposition (Name of y, crematory or other place	ce)	Date	20c. Location -	City or Town, State	
Ē	. Pag Iment Ient:		4 ☐ Donation 5 ☐ Other (Specify)	1, 44	een	of Peace Cer		6/23/07	Helen, l	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiens. Importent is the straint and Mantal Hygiens in returnet, or items 23a or 286-f show importent; items 23a or 286-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	12/2 Die	TT Name of	22. Name and Addres	ss of Facility Br	insfield	d Funera	1 Home, P.	Α.
	40 = 60			101206	_	22955 Holl	ywood Ro	ad, Leon	nardtown	, MD 2065	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the dea le cause on each line.	ıth. Don	ot enter the mode of dyin	ig, such as cardia	c or respiratory a	rrest,	Approximat Interval Bet Onset and I	tween
	Physician /Medical		Immediate Cause (Final	1.		^)				Onserand	1
	Examiner		disease or condition resulting in death)	L)	M)	Shona				MON	1h5
		Je.		Due to (	or as a c	onsequence of):				i	
	rificate be executed ng physician and as the burial-transit	Examiner	Sequentially list conditions	. — Due to (	or as a c	onsequence of):					
Ö,	e exection and are are are are are are are are are are	Ä	Sequentially list conditions, if any, leading to immediate cause First I denote Cause (Disease or injury								
68760,	death certificate be executed e ettending physician and ed for use as the burial-transit	Medical	that initiated events resulting in death) Last	Due to (	or as a c	onsequence of):					
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7	that that hed by deta		WHO					1 🗆 1	Yas 2⊠ No	3 Probably 4 □	Unknown
Vital Records,		ed by							an autopsy	24b. Were autopsy f	findings
ပ္သ	w rec	Set						репо	rmed?	available prior t completion of c of death?	
Ä	The law cate has page 2	Completed						101	res 2 ØNo	1 ☐ Yes 2 ☐	No
		Bec	25. Was case referred to medical				26. Place of Dea	ath (Check only o			
> io	Q 50 78	2	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐	] ER/Out	patient 3 DOA Othe	er: 4 Nursing H	lome 5 ☐ Resid	dence 6 Othe	er (Specify)	
	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. T	jury Worl		28d. Describe h	now injury occurr	ed	
<u> </u>	Attending or death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		<u> </u>		Yes 2 □ No				
	of or Attending a feet death.  Director: A din by the fu	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, far <i>ify)</i>	m, street, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	<i>er or Rural Route N</i> um	iber,
_	spital ours a ours a illed		29a. Certifier 1 Cartifying Phys	ician: To the best of my kno	owiedze	death occurred at the tim	ne, date and place	and due to the	ceuse(s) and ma	nner as steted	
	To the Hospital within 24 hours a Vithin 24 hours a To the Funerei Completely filled	edicai	(Check only 2 Madical Examin	ar: On the basis of examina and manner stated.	ation and	/or investigation, in my or	pinion, death occu	irred at the time,	date and place,	and due to the cause(s	;)
	To the within 2 To the comple	Me.	29b. Signature and title of certifier	A		29c. License	e number			d (Month, Day, Year)	,
_			N. Jan 1	N/		10	41978	5	6-2	21-200	/ /
1	)(,		30. Name and address of person who con	npleted cause of death (Ite	m 23a) (	Type, Print)	1111	e Ad	RA	21-200 10 M	
1	5		1000	okshi 1	100	Mijoh	HIVILV	e 10 a	(300	20	716
	Stat Registra		31. Date filed (Mont) 18 2 8 20	37 legistrar's Sign	ature	1. 44					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04634 State of Maryland / Department of Health and Mental Hygiene Alana Nicole Norris 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 17, 2007 1358 hrs Medical Examiner NICOLE NORRIS ALANA 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Days Hours Director Country) MD 1 M 2 X F 16 N/A Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Gaithersburg s 23a or 28a-f shov e notified at once. MD Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7900 Spiceberry Place 20877 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Yes Black If Yes, Give Year Specify: Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. traumatic event, the Medical Examiner Widowed Δ Divorced "natural", ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than N/A N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Norris Stephanie Fennell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) tant: If item 27 is or other traumatic 7900 Spiceberry Pl. Stephanie Fennell (Mother) Gaithersburg,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ment ( 6/28/07 Lincoln Park Cem Rockville,MD Donation 5 Other Specify 22. Name and Address of Facility SNOWDEN FUNERAL HOME. 21. Signature of Funeral Sérvice Lucey ee 246 N. Washington St, Rockville, MD 20850 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and List only one cause on each line /Medical Death Sudden unexplained death in infancy Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED ##**ESB,**PII,27,28a-f, perME,g869, 7/25/07 TT use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Brainstem tumor Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 V Yes No 26.Place of Death (Check only one) 25 Was case referred to medical of Vital 8 examiner? Other<sub>4</sub> Hospital: Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ۵ 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2 X No Division 5 Pending the f Fnd 6/17/2007 Fnd 1:02 pm unk 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City X Could not be 3 or Town, State) Suicide 24 hours a Funeral I (Specify) 7900 Spice Berry Circle Gaithersburg residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. June 18, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner gistrar's Signature 31. Date filed (Month) State 2007 Registra

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUIV Day Physician 3, 200<del>7</del> 2:35P. M Yefim Okun /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth Aug. 25, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Belorussia 577-17-0529 91 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at death with the Marylar Maryland Montgomery Chevy Chase 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? a or 4707 Chevy Chase Drive, #310 20815 United States ns 23a must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No White Specify: Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Russian Science Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer the Institute 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Okun Boris Esther Samanovcky ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other trauonce. Jenny Okun -wife 4707 Chevy Chase Drive,#310 Chevy Chase, Md. 20815 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean Memorial Gdns 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7/5/2007 Olney, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lio Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last anding physician and use as the burial-tran Due to (or as a consequence of): Divísion or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Failure; Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s performed? Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and fitle of 29d. Date signed (Month, Day, Year)

Registrar

KUN, YEFIM

Steven D. Wilks, M.D. 31. Date filed (Month, Day, Year) State JUL 1 0 2007

8600 Old Georgetown Road Bethesda, Maryland 20814 . Registrar's Signature

Wilks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D063195

July 4, 2007

ewis William Pfelt	1-	Jr. State of Maryland / Department of Health and M - For State Certificate of Death egistrar	/lental Hyg	giene Reg	. No. 21	07 2215
Physician/	1	I. Decedent's Name (First, Middle,Last)		Date of Death	Day Year	3. Time of Death 0219 hrs
ledical Examine		Lewis William Pfeltz, Jr.  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca		July 3, 200	4c. County of [	
	1	N/B White Hall RD near I-70 overpass  Hagerstown			Washingto	
Funeral		Joseph Jo	f Under 24Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
Director	İ	212-82-9065   1X <sub>M 2</sub> F   45	Hours Min.	May 15	, 1962	Country) Maryland
some a more than the second floor of the second second	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
daryland 28a-f show any d at once.		MD Washington Hagerstown				1 X Yes 2 No
ryland a-f sh tf once	<u> </u>	10e. Street and Number . 10f. Zip Code		100	g. Citizen of What	: Country?
th the Maryland 23a or 28a-f sho notified at once		236 Frederick St. 21740			U.	S.A.
215-0036 be filed within 72 hours after death with the Maryland nial Hygeine. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Re Compulated by Funeral Director		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani				American Indian, Black,
or items 23	5	Never Married 2 Married 1 Yes 2 X No		ilouri, otoly		
s after	<u>-</u>	3 Widowed 4 X Divorced of Yes, Give Year 1 Yes 2 X No sport Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (		rk done	Specify: \( \frac{1}{N} \)	
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21215-0036 wild be filed within 72 hours. Mental Hygiene. marked other than "natury c event, the M. dicel Exami		, , , , , , , , , , , , , , , , , , , ,			aiden Surname)	
2121 Ild be fill Mental I marked event,		Lewis William Pfeltz, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	Mary Ze		per, City or Town,	State, Zip Code)
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MOI Pages ent of ent of int: If		4 Donation 5 Other Specify Smithsburg Cremator	cy 7/7/	2007		ourg, MD
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	1	21. Signature of Funeral Service Licensee 22. Name and Address of F				-
	1	S. Mark Some 1601 Pennsy1  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such				
Physician /Medical	1	failure. List only one cause on each line.	•			Between Onset and Death
raminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):		a e		
т.		Sequentially list conditions, b				
9		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	200.171			
ريه يهور	X	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
SO, te be executed by sician and be burial - transit	5	d. UNPENDED AMENDED				
50, tte be e hysicia e buria		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of d	elivery
cox 6876 eath certificate at the discussion of the control of the	2	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnar	ісу	Month	Day Year
the death certificat the death certificat yy the attending pheched for use as the	5	1 Yes 2 No 9 Unknown g Unknown			1	
that the d the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	n in Part I.	23e. Did tot	pacco use contrib	ute to the cause of death?
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ords, P				24a. Was a autops	sy pri	ere autopsy findings available for to completion of cause of
Cecc	Completed			perform 1 <b>V</b> Yes 2		eath? ✓ Yes 2 No
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F Vid	<u> </u>	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA		,	Residence 6	
Vision of or Attending Ph. Rer death. Director: After in by the funeral		(Month, Day, Year)			ixed object co	
isio		2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office build	ding, etc.			r or Rural Route Number, City
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e Hosp 24 ho e Fune etely f	<u>,</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a Check only	and place, and	due to the cause	e(s) and manner a	as stated.
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ᇟᆫ	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.  29b. Signature and title of certifier  29c. License nu		the time, date a		d (Month, Day, Year)
	≥	29b. Signature and title of certifier  29c. License no O.C.M.E			July 3, 2007	
	-	30. Name and address of person who completed cause of death (Item 23a)				<del></del>
H		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201	I		
Sta		31. Date filed (Month Day, Tear) 2007 32 Registrar's Signature				
Registra	ar	The same of the same				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Albert A. Phillips, Jr. 6 23 2007 12:05 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 213-16-0699 1 XM 2 □ F 86 Director 5/22/1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at Maryland 1 ☐ Yes 2 XNo Carroll Hampstead Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. It flem 27 is marked other than "natural", or items 23a or into rother traumatic event, the Medical Examiner must be any or other traumatic event, the Medical Examiner must be a support. 4612 Upper Beckleysville Road 21074 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1942— If Yes, Give Year or Dates: 1945 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postmaster Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert A. Phillips, Sr. Leota Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any injury or other trac Carroll Phillips - Son 2837 Tracey Mill Road Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Carroll Cremation 6/25/2007 Hampstead, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Eline Funeral Home, 934 South Um M01490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate l 1□ Yes 2 No or Attending Physician; funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospice 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural
2 Accident Injury 5 Pending investigation 1 Tyes 2 □ No s after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) NJL 30. Name and address of person cause of death (Item 23a) (Type, Print) TOOA POOLE NO

STIVA

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 2 6 2007

			1 - For State Registrar	State of I	Marylar				lealth a			Reg. No.	007	É	221	57
	Physici	an	Decedent's Name (First, Middle, Kay Amelia Ph	=							2. Date of De June	ath 24	200	(7	3. Time of [	
	/Medi	cal	4a. Facility Name (If not institution,	<del>_</del>	ar)		4h Cih	Town of	Localion	of Death			ounty of De		6615	M
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	Funeral			i. Sex 7.		. last birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da		9. B	irthplac	e (State or	
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	arylan show		10a. Slate 10b. County		10c. C	ity, Town or Lo								10d	. Inside City	
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	Jeeth mus 23	Funeral Director	13008 Blairs	12. Was Decede		J.S.   13.	Was Dece			gin? (Spe	cify Yes or No	)- 14	I. Race - An		Indian.	
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23a or 28s-f ehow aumatic event, the Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☐ Marrie  \$ ☐ Widowed 4 ☐ Divorced	Armed Force	ıs? ⊡ No		lf Yes, spe 1 □ Yes		n, Mexican Specify:	, Puerto I	cify Yes or No Rican, etc.)	I	Black, Wi pecify: <b>V</b>			
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Ë	Page Tent of Int: If		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			airs V				6-30	-07	Clear	Spri	ng	Maryl	and
Baltimore,	mit. partm porta y inju		21. Signature of Funeral Service Li	censee	- 70	22	. Name a	nd Addres	s of Facilit	y Dou	glas A.			_		
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,09/	ate be executed //Medical	cal Examiner	shock, or head/failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or	as a consecutive as a c	quence of):			RHA					0	iterval Belw nset and Di	
P.O. Box 687	death certific e attending p id for use as f	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 □ Yes 2 ☑ No 9 □ Unknown	d.  23c. If yes, outcom 1	2 ☐ Feta at lime of d	al death 3	Ectopic p Other (s					23	d. Date of d Month	elivery Da	ay Ye	ear
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or Vital	Phyaician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	tiont OF	TER/Out-sties		Othe			(Check only o		70			
	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of It		ER/Oulpatier 28b. Time of		28c. Injury	at		ne 5 Aesi			ecity)		
<u></u>	Attending I r death. ector: After by the funer	atlo	1 Matural 5 Pending 2 Accident investiga		Jay Year)	Injury	М	Work	(? Yes 2∐t	No						
Division	i Diffe	Certification;	3 Suicide 6 Could no determin	ad 286. Place of	Injury - At h etc. (Speci	ome, farm, str	eet, factor	y, office		2	8f. Location (: City or Tou		Number or i	Rural F	oute Numb	8 <i>r</i> ,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the be aminer: On the basis and manner	of examina	owledge, death ation and/or in	occurred vestigation	at The tim	e, date and pinion, deal	d place, a	nd due to the ad at the time,	cause(s) ar date and p	nd manner lace, and d	as state	ed. e cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	.11			29	c. License	number			29d. Date	signed (Mo	nth, Da	y, Year)	
			Marsh	Then A	1			Do	5010	OPC		06-	28-	200	0)	
4	11 00		30. Name and address of person when the same address of person when the same and address of person when the same address of person whe	no completed cause of 322	f death (Iter	т 23а) (Туре,	Print)						2			
	4-8		31. Date filed (Month Day Year)	322 Jan	strar's Sign	2077 6 7 .	Tres.	51,1	4116	5ns	, GINEL	no -	1174	)		
	Sta Registr		31. Date filed (Month Day Year)	2007 62	Personal Control	M. 1.	a de	,								

			T- State of N	/laryland / D		tment of H ificate of L		d Mental H	ygiene Reg. No.	07	22158
	Physici /Medi		1. Decedent's Name (First, Middle, Last) RITA MARGARET POWER	S				2. Date of D Month JUNE	Day	2007	3. Time of Death 10:15AM
	Examir		4a. Facility Name (If not institution, give street and numbe Reeders Memorial Home	r)	4	b. City, Town, or Boons		eath		ity of Death	
4	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F 7. /	Age (In yrs. last birt		If Under 1 Year Months Days	If Under 24 I Hours M	lin. (Month, E	irth Day, Yea <i>r</i> ) 16,1925	Cou	place (State or Foreign ntry) Virginia
	Maryland -f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Frederick	10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 ▼ No
	vith the	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen o		•
036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	2708 Monocacy Bottom Road  11. Marital Status  1 Never Married 2 Married  3 Not Midowed 4 Divorced  1 Yes 2 If Yes, Give Year or Dates	s? Î No		21710 us Decedent of Hi res, specify Cuba Yes 2XNo	spanic Origin: n, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)	lo- 14. R	d Sta ace-Americack, White, city: Whi	can Indian, etc.
9500-61212	vithin 72 ine. ihan "na ie Medic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40	r 5+)	(Give kir. life. DO	nt's Usual Occupa nd of work done of NOT use retired, Lcian	ation during most of )	working	16b. Kind of		•
2	ould be filed v I Mental Hygie Iarked other t	To Be C	17. Father's Name (First, Middle, Last) Grover Dove					Name (First, Middl abeth Cat	•	,	r
, mary	permit. Pages 1 and 2 should be Depcrument of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type. Print)  Jerald Dove (Son)	27	708 M	ionocacy	Botton	r Rural Route Num n Road A	ber, City or Tow damstow		- 1
altimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition  1   □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	ie	t Oak	ion (Name of tory or other place Cemete:	ry   30	ne 23, 2007	20c. Location	rsbur	
Dail	permit. Depert Import any Inj		21. Signature of Funeral Service Licenses  Like E. Day		22. N	lame and Addres	er Parl	DeVol Fun DR. Gai	eral Ho thersbu	me rg, M	D 20877
8700,	Physician but have been but have been but have but a street but a street but have but a street but have but hav	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	line.  as a consequence of the sequence of the	of):		y, 50011 00 out	and of respiratory	urrost,		Approximate Interval Between Onset and Death
.O. DOX 00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med		2 ☐ Fetal death at time of death		ctopic pregnancy hther (specify)				Date of delive	ery Day Year
ecords, r	equires that en signed b		Part II. Other significant conditions contributing to death	but not resulting in	the unde	erlying cause give	en in Part I.		tobacco use co Yes 2⊠No		he cause of death? bably 4  ☐Unknown
necc	> 9 70	Completed by	U U		<i>(</i> /			24a. Wa aut per 1□ Yes	s an 24b opsy formed? 2 No	o. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
\ \ \	/slclan s certifi director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa	tient 2∏ER/Out	toatient	3 DOA Othe		Death <i>(Check only</i> g Home 5 ☐ Res		thor /Cassi	6.0
	To the Hospital or Attending Physician: The law within E4 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death  1 Natural 5 Pending (Month, December 2) Accident	njury 28b. T		28c. Injury Work			how injury occu		(y)
DIVISION	Ital or Atterns after de ral Directo	Certification:	4 Homicide determined building,	njury - At home, fan etc. <i>(Specify)</i>				City or To	own, State)		al Route Number,
	le Hosp 24 hou le Fune detely fi	edical	29a. Certifier (Check only one)  1 CertifyIng Physician: To the besing and manner:  2 Medical Examiner: On the basis and manner:	of examination and	e, death o d/or inves	ccurred at the tim stigation, in my op	ne, date and ploinion, death o	ace, and due to the accurred at the time	e cause(s) and r e, date and place	nanner as s e, and due t	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. License			29d. Date sign	ied (Month,	Day, Year)
•	10		30. Name and address of person who completed cause of	death (Item 23a) (7				RAI VND 51	6/20/	0/	-2222
i	Sta Registi			Strar's Signature	L, N	LLDI3VIL	۱۱۳۸ و ساسا،	NILAND Z.	2730 30		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 18, D2007 **Physician** Pechter Ann 5:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Heartfields Assisted Living Bowie Prince George 8. Date of Birth (Month, Day You June 29, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Phil. PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗡 F Min 199-18-7147 80 Yrs. Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
snt: If Item 27 is marked other then "natural", or Items 23s or 28s-1 show ury or other traumatic event, the Medical Exeminar must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7600 Laurel Bowie Road 20715 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Soloner 2 Katherine Korn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Ellis, daughter 12205 Guinevere Road, Glenn Dale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory June 19, 2007 Alexandria, Virginia Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road, Beltsville, MD 21. Signature of Funeral Service License 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Cardiomyopathy 12 months /Medical Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner Hospitel or Attanding Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an 7 No 1☐ Yes Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2X No this 28c, Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Xatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ŝ 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifie 29c. License number 0 D32261 June 19, 2007 30. Name and address of person of mpleted cause of death (Item 23a) (Type, Print) Dr. Richard Feldman, 9500 Annapolis Road, Lanham, Maryland 20706 31. Date filed (Month, Day, Year) JUN 2 2 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

07-04901	
Roberta Petty	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

oberia Felly		1- For State State of Maryland / Department Registrar Certificat	e of Death	Reg. No.	007 2216
Physi ledical Exa		Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year  June 27, 2007	3. Time of Death 2148 hrs
euicai Exai	IIIIIe	Roberta Ann Petty  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
		Calvert Memorial Hospital	Prince Frederick	Calvert	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	yrs. If Under 1 Year If Under 24Hrs  Months Days Hours Min.		Birthplace (State or Foreign Country) MD
any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits
*	at once.	MD Calvert Lusby			1 Yes 2 X No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she	Dire		10f. Zip Code 20657	10g. Citizen of Whated	
eath wit	must be no Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>		- American Indian, Black, , etc.
after de	by Ft	3 Widowed 4 Divorced lit Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify:	White
hours	Exam fed t		cedent's Usual Occupation (Give kind of v ring most of working life. DO NOT use reti		siness/Industry
036 thin 72 ne.	the Medical Examiner Completed by	12 Ho	usewife	Own He	ome
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	C Fe	177. I differ a Natifie (First, Milodie, Last)		e (First, Middle, Maiden Surname)	
2121 ald be f Mental marke	To Be	Peter M. Preston	Alice S  Mailing Address (Street and Number or F		n, State, Zip Code)
MD d 2 shor lith and n 27 is	matic	Robert Wayne Petty (Husband) 77	9 Crazy Horse Trail	l, Lusby, Maryl	and 20657
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other th	other traumatic	1 Burial 2 X Cremation 3 Removal from State cremator	Disposition (Name of cemetery, y or other place)		City or Town, State
Baltimore, permit. Pages I ar Department of Her Important: If ite	÷	4 Donation 5 Other Specify: Metrop	olitan Crematory 7,		
Bal permi Depar	injury	21. Signature of Funeral Service Licensee	P. O. Box 600, Li	Rausch Funeral lusby, Maryland	
Physicia		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.			
/Medic	_	Immediate Cause (Final disease or condition resulting in death)  a. Trandol and imi ramine Due to (or as a consequence of):	e intoxication		Death
		Sequentially list conditions,  b.			
	iner	if any, leading to immediate Due to (or as a consequence of):			
78	nsit Samin	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
760, cate be executed physician and	튀 등	I 6	060 7/11/07 -		
O. O. Box 68760, that the death certificate be exert for the attending physician ned by the attending physician	he burial - tr. Medical		.g869. //11/0/ TT	23d. Date of	delivery
certificanting	or use as the	23b. Was decedent pregnant in the past 12 months?    1   Live birth   2	Fetal death 3 Ectopic pregna Other (Specify)	ancy Month	Day Year
Box e death the atte	Physic	1 Yes 2 No 9 V Unknown g Unknown			
, P.O. res that the signed by	detach		n the underlying cause given in Part I.	23e. Did tobacco use contri	bute to the cause of death?  Probably 4 V Unknown
rds, I requires been sig				24a. Was an   24b. V	Vere autopsy findings available
ecor e law r te has b	61			performed? d	rior to completion of cause of leath?  Yes 2 No
tal Reco cian: The law certificate has	Rector, pa		26.Place of Death (Check		V res Z No
n of Vita ing Physici After this co	funeral director, page	1 Yes 2 No Inpatient 2 ER/Out		ng Home 5 Residence 6	Other:
n of ding F h.	e funer	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Til Natural 5 Pending 28b. Til 28b. Ti	me of Injury 28c. Injury at Work?	28d. Describe how injury occurre	ec
/isio	lled in by the fune	2 Accident Investigation FND 6/27/2007 FND 8  3 Suicide 6 X Could not be	n, street, factory, office building, etc.	28f. Location (Street and Number	er or Rural Route Number, City
Div pital o ours af eral D	Cort			or Town, State) 779 Crazy Horse Tr	rail Lusby, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in		n occurred at the time, date and place, and estigation, in my opinion, death occurred a	I due to the cause(s) and manner at the time, date and place, and d	as stated. ue to the cause(s)
To To	S N	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signe	ed (Month, Day, Year)
		auetz.	O.C.M.E.	June 28, 20	007
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 2120	1	-
	State	a 31. Date filed (Month, Day, Year)			
Reg	jistra	TO SUM S LOUI MARIE, S. DO	we will		

		1 - For State Registrar	State of	Maryland		rtment of F		d Mental Hy	/giene Reg. No.	107	22161
Physici /Medic		Decedent's Name (First, Middle		m Donald	d Pacl	card		2. Date of D Month July	eath Day 1, 20	07	3. Time of Death  10:55 A <sup>M</sup>
Examir		4a. Facility Name (If not institution,	give street and numb	ber)		4b. City, Town, or	Location of D			unty of Death	
		10933 Gaywood 1					erstow			Washin	
Funeral Director		006-14-5057	6. Sex 7. 1 ★M 2 F	. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, D	irth Pay, Year) 17, 192	Cou	place (State or Foreign ntry) Maine
and		Usual Residence of Decedent  10a. State 10b. County		10c, City, 1	Town or Loc	cation					10d. Inside City Limits
Maryli f eho	៦	,	• • •								1 ☐ Yes 2 ☑ No
the 288	rect	Maryland Wash	ington			10f. Zip Code	stown		10g. Citizen	of What Cou	ntry?
3a or	Funeral Director	10933 Gaywood	Drive				21740			U.S.A.	
death	ner	11. Marital Status	12. Was Deced		13. V	Vas Decedent of H	ispanic Origin	? (Specify Yes or N		Race - Ameri	
DEMILITIONEY, INTERTY IGING A LA 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event. The Medical Examinar must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🎇 Divorced	Armed Force of 1 [X]Yes 2 If Yes, Give Year or Date	! □ No	i	Yes, specify Cuba	Specify:	rueno Rican, etc.)		Black, White, ecify: W	hite
2 hour	ted	15. Decedent	s Education		16a. Deced	ent's Usual Occup	ation	dua	16b. Kind	of Business/In	ndustry
thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. E	kind of work done of OO NOT use retired	during most or f)	working			
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d be file of the other	Be	17. Father's Name (First, Middle, L						Name (First, Middle		,	
Vica ould Men Men marke	ဥ	Fred A. Packaı						by M. McC			
VICE Sh 12 S	li	19a. Informant's Name/Relationsh		1		•		or Rurai Route Numb			
ther t		Ginger L. Brind	lley (Daug	ghter)				agerstown		Land 2	
Egges Hoff erg		1 Burial 2 Tremation		late		sition (Name of patory or other place	, .	July 2,		•	
DCILLITION Dermit. Pages Department of mportant: if it iny injury or o		4 □Donation 5 □ Other (Sp 21. Signature of Funeral Service L	<del> </del>	Smit		g Cremat Name and Addres		2007			Maryland
Department of the police of th		T=00-	/	:- 1/1-1	. 577			J.L. D			
SAME S		231 Part1. Enter the disease, or	complications that cau	used the death.	Do not ente	or the mode of dvin	o. such as car	ve. Smith	arrest.	Maryı	Approximate
		shock, or heart failure. List of Immediate Cause (Final	only one cause on eac	ch line.				,			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Mysc	ardial	inta	rchon					Hours
Examiner			Coron	acu ac	- La r 4	r ction disea	50				Years
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an ar	EX	resulting in death) Last	Due to (or	r as a consequer	nce of):						
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entific ling p		IF FEMALE:	3								
ath cer	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Fetal de	eath 3	Ectopic pregnancy			23d.	Date of deliver	ery Day Year
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9□Unknow	nt at time of deat vn	th 5∐	Other (specify)					,
T.		Part II. Other significant condition	ns contributing to dea	th but not resulti	na in the un	iderlying cause give	en in Part I	23e. Did	tobacco use	contribute to t	he cause of death?
w requires to the state of the	d by	Chronic obstru		monary		sease, h		12	<b>√</b> es 2□N	lo 3 Prol	bably 4 Unknown
v requ	ete		pre			1000	710	24a. Wa:	200	4b Wara auto	and findings available
he lav	Completed	Thyroidism						auto		prior to co death?	opsy findings available impletion of cause of
n: Ti	ပိ	25. Was case referred to medical						1 Tes	2 No	1 🗌 Yes	2□ No
valcia s cert direct	To B	examiner?	Hospital:	nationt 2 🗆 EB	VOutpatient	3□ DOA Oth	00	Death Check only	1.00	Other (Specia	6.1
eral c		27. Manner of Death	2Ba. Date of	Injury 28	3b. Time of	2Bc. Injun Worl		28d. Describe			(9)
Attending r death. ector: Atte	atio	1 Accident 5 Pending 2 Accident investig.		Day Year)	Injury		Yes 2 □ No			Ę	
Atte	ii ii	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 288. Place of	f Injury - At home	e, tarm, stre	eet, factory, office		28f. Location	(Street and No	umber or Rur	al Route Number,
talor safte	Certification;		Duliding	g, att. (apacity)				City of Te	, Jiaio/		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Attending physician has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the b xaminer: On the bas and manne	is of examination	edge, death n and/or inv	occurred at the timestigation, in my of	ne, date and p pinion, death o	lace, and due to the occurred at the time	cause(s) and , date and pla	d manner as s ice, and due t	stated. o the cause(s)
To th within Fo th	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date si	gned (Month,	Day, Year)
		M MD				058	195		07/	02/20	007
Б		30. Name and address of person v	. 1			Print)				•	
5		31. Date filed (Month, Day, Year)		gersto w		U d	740	· · · · · · · · · · · · · · · · · · ·			
Sta Registr		1111 1 0 2		gistrar's Signatur	Land	d;					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2

1- For Amend PI, line a-c, 25, 27, 28a-f, per NF 103/1, 9 27 17

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE **Physician** 1247 25 Ronney Lee Renner, II 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours **1**∕ M 2 □ F 219-68-0221 52 Jan. 11,1955 Maryland **Director** Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2√XNo Directo Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17112 Reedy Parkway 21740 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XX Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Laborer Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Ronney Lee Renner, Sr. Peggy Lorraine Zimmerman မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 item 27 Kathryn B. Renner - Stepmother 100 Eastview Drive Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or once, # ō 4 Donation 5 ☐ Other (Specify) June 29,2007 Williamsport, Maryland Greenlawn Mem. Park 21. Sanature Funeral S OSBOTTE ATTOM EFEMILY Home, P.A. 21795 #25 S. Conococheague St. Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 Cardiac /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Shirdtion neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examiner Choking aftending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy this certificate 1∐ Yes 2 No director 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Sunpatient 2 ER/Outpatient 3 DOA After the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation Injury subject choked on food bolus 1 ☐ Yes 2 XNo 2 Accident 3 Suicide June 23, 2007 unk 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 433 Brewer Ave. Hagerstown, MD Assisted Living Unit

The law requires that the death certificate be executed Box 68760, P.O. Division or Vital Records, or Attending Physician:

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 66-26-2007 P52323 Hagerstown Maryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court 1311-2 Waseem 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 2007

Registrar

29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1 - For State Registrar	State of Maryla	ind / Dep	artme		ealth and l	Mental Hyg		200.	7 22163
Ī	Physici		1. Decedent's Name (First, Middle, Las	n) 1 Nathan ROSN	IER				June 20		007 Year	3. Time of Death 7 : 50 A M
-	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			y, Town, or ethesd	Location of Deat		4c. (	County of De	
Ī	Funeral Director		213-01-7023	9x 7. Age (In year) 7.	rs. last birthday, Yrs.		ler 1 Year s Days	Hours Min.	8. Date of Birth (Month, Day April 3	Year)	9. B Ma	irthplace (State or Foreign County) ryland
	Maryland e-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgom		City, Town or L							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with th	al Director	10e. Street and Number 4400 East West Hi	ghway #707		10f. 2	Zip Code 20814			-	en of What C	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23e or 28e-f show simportant: If Itam 27 is marked other than "natural", or Items 23e or 28e-f show any july or other traumatic avant, I'lle Micalcal Enatural trained to inclinity and once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces? 1 Xi Yes 2 □ No If Yes, Give Year or Dates:			cedent of His becify Cubar 2 X No		pecify Yes or No- lo Rican, etc.)	ł	Black, Wh	nerican Indian, hite, etc. hite
1215-0	within 72 horens.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	e kind of v DO NOT	sual Occupa work done di use retired)	tion uring most of wo	rking		d of Busines	•
Maryland 21215-0036	ould be filed Mental Hygi arked other stic avant,	To Be Co	17. Father's Name (First, Middle, Last) Philip Rosn						me (First, Middle, Bergner	Maiden S	Sumame)	
Mar	alth and 27 is mu		19a. Informant's Name/Relationship (18 Beth Rosner, Daug						thesda,		Town, State, 20814	, Zip Code)
Baltimore,	Pages 1 and neut of Heisen ant: If Itsm		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	rigilioval liulii State   _	Place of Disp cemetery, cre idean M	osition (A ematory o	lame of r other place <b>ial Ga</b>	06/2	Date 2/07		eation - City o	or Town, State
Balt	permit. Departr Importe sny Ini		21. Signatur of Fun yral Servic Cicen	500			-		Funeral W. Washi	Home	7.35	20012
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the done cause on each line.  a. Metastati  Due to (or as a cons	c Carci		ode of dying	, such as cardiad	c or respiratory ar	rest,		Approximate Interval Between Onset and Death 3 Months
68/60,	eath certificate be executed attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons  d.								
Jivision of Vital Records, P.O. Box to	Attanding Physician: The law requires that the death certifical robath.  robath.  sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the state of the s	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic □ Other	pregnancy (specify)			2	3d. Date of d Month	lelivery Day Year
rds, P	w requires that been signed b should be deta	ed by Pt	Part II. Other significant conditions of Deep Vein Thrombo		esulting in the (	underlying	g cause give	n in Part I.		bacco us		to the cause of death?  Probably 4 □Unknown
II Reco	The law recate has been page 2 sho	Completed		_					24a. Was autop perfor 1 🗆 Yes	sy med?	death?	autopsy lindings available o completion of cause of es 2 \sum No
VIE	certific	Be	25. Was case relerred to medical examiner?  1 ☐ Yes 2 🕅 No	Hospital: 1 ☐ Inpatient 2			Othe		ath (Check only o			
sion of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	27. Manner of Death  1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation	28a. Date of Injury (Month, Day Year,	28b. Time of Injury		28c. Injury Work	4   Nursing r	dome 5 Resid			ieciry)
N N	5 th 6		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, si	treet, fact	ory, office		28I. Location (S City or Ton			Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 ☑ Cartifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my k ninar: On the basis of exam and manner stated.	(nowledge, dea ination and/or in	ith occurre	ed at the time on, in my op	e, date and place inion, death occi	a, and due to the durred at the time,	ause(s) date and	and manner and di	as stated. ue to the cause(s)
)	10+1	₹	29b. Signature and title of certifier		) 4		D 00	number )30484			ne 20,	nth, Day, Year) 2007
			30. Name and address of person who Charles A. Umosel	la. M.D., 76	25 Wisc	onsi		, #101,	Bethesd	a, M	D 208	314
7	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 2 20	07 Samegistrar's Sig	A A	and the	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:45 рм June 15 2007 Katherine Reynolds /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 5 Delford Avenue Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Days 1 ☐ M 2 🗓 F Yrs. Kansas December 15,1927 Director 509-24-7733 79 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ä 1 ☐ Yes 2 No notified Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code t0e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyghen.

Department of Health and Mental Hyghen.

The most parameter of the tran "ratural", or items 23a or any injury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be really injury or other traumatic event, the Medical Examiner must be really injury or other traumatic event. 20904 U.S.A. 5 Delford Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛭 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Work Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First. Middle, Last) Be Ingaborg Carlson Herbert W. Dean ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Delford Avenue, Silver Spring, Maryland 20904 Daniel Reynolds - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 □Removal from State 1 ☐ Burial 2 X Cremation 6/26/2007 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Vice Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 X No 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Division Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Mogth, Day, Year) 29b. Signature and title of ess of person who completed cause of death (Item 23a) (Type, Print) Jack Richard Epstein, M.D., 10810 Connecticut Avenue, Kensington, Maryland 20895 egistrar's Signature 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 1/2001

Registrar

JUN 22

2007

			For State Registrar	State of Marylar	id / Depa <i>Cei</i>	artmen rtificate	t of H e <i>of L</i>	ealth a D <i>eath</i>	ind Me	ental Hy	giene (	2007	22	165
10	Physici	an	1. Decedent's Name (First, Middle, Last) Mike Theodore	Poinbardt						2. Date of Dea Month	Day	Year	3. Time o	
	/Medic Examin	al	4a. Facility Name (If not institution, give s Prince George's	street and number)			Town, or	Location o	f Death	06-23	4c. Co	ounty of Death		РМ
1000	Funeral Director	करने ।	5. Social Security Number 6. Sex 229-20-0600		last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birt (Month, Da 11-30-	h y, Year)	9. Birth	nplace (State of Intry) irginia	or Foreign
	Maryland 8-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Ge		y, Town or Lo								10d. Inside C	ity Limits 2 No
	with the	Director	10e. Street and Number 5805 Dewey St.	reet		10f. Zip		785			10g. Citize	on of What Cou	untry?	
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f ahow event, tre Medical Exartinar must be notified at	by Funeral	11. Marital Status  1 Never Married 28 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 45 - 4		Was Deced If Yes, spec		spanic Drig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- lican, etc.)		Race - Amer Black, White		
21215-0	d within 72 ho giene. or than "natur I're Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Dece (Give life. Dry C	kind of wo DO NOT us	rk done a se retired	luring most )		i i		of Business/I	•	
yland	jes 1 end 2 should be filed w of Health and Mental Hygier If item 27 is marked other th or other traumatic event, In	To Be	17. Father's Name (First, Middle, Last) Theodore Carrol Rei							(First, Middle, Markery		umame)		
, Mar	and 2 sho laith and 27 is ma	The state of	19a. tnformant's Name/Relationship (Ty) Ruth Jefferson Rein			-				Route Number		70wn, State, Z 20785	ip Code)	
Baltimore, Maryland 21215-0036	permit. Pages 1 ( Department of He  important: If item  any inlury or oth  once.		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Light	emoval from State For		natory or o n Cen 2. Name an	ther place neter nd Addres	y   is of Facility	5-28- y 4	739 Ba	Brent 1timo		Maryla nue	
8760,	Physician /Medical Examiner	dical Examiner	23d. Part1. Enter the disease, or comblishock, or heart failure. List offly on the time of the time of the time of the time of the time of the time of the time of the time of the time of tim	Cations that caused the deather cause on each line.  Interstit  Due to (or as a consect  Cardiomyc  Due to for as a consect  Congested  Due to (or as a consect  Due to (or as a consect  Congested	h. Do not ent cial Lu puence of): pathy puence of).	er the mod	le of dying	g, such as (					Approxima Interval Be Onset and	te tween
O. Box 6	death certif e attending ed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	ıl death 3 [	Ectopic pr Other (sp					23	d. Date of deli Month		Year
rds, P.	9 50	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying c	ause give	en in Part I.			obacco use	o contribute to	the cause of	
al Records,		Completed										24b. Were au prior to d death? 1 ☐ Yes	omptetion of a	available cause of
Vital	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 1⊠Inpatient 2□	ER/Outpatier	nt 3 🗆 DC	Othe			Check only one		☐Other (Spec	cify)	
Division of	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 X Naturat 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f M	8c. Injury Work	rat c? Yes 2□h		8d. Describe I	now injury (	occurred		
DIVIS	P S S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At h building, etc. (Speci	ome, farm, str y)	reet, factory	, office		2	8f. Location (S City or Tov	Street and i vn. State)	Number or Ru	rai Route Nur	nber,
	~ E → O	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.										s)
)	To the H within 24 To the Fi	Me	29b. Signature and title of certifiar			290	D58	number 3182				signed (Monti		
)	(10)		30. Name and address of person who co C. Donald George,				ever	ly. M	[arv1	and 20	785			
	Sta Registr		31. Date filed (Month, Day Year) JUN 2 6 2007	32. Registrar's Signa				,,	-/-				-	

		State  State	e of Maryland / Depa	artment of Health and Martificate of Death	lental Hygie	_	2216
		Registrar  1. Decedent's Name (First, Middle, Last)		timeate or beaut	2. Date of Death	. 140.	3. Time of Death
Physi	cian				Month	Day Year	
/Mec		John Stafaniak, Sr.		# 05 T	<u>July</u>	2 2007 4c. County of Death	│1955 <sup>™</sup>
Exam	iner	4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death			
		Harford Memorial Hos		Havre de Grace		Harford	(0)
Funera Directo		5. Social Security Number 6. Sex 125 M 2□	F 90 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) 6/9/191	year) 9. Birth Coui Penr	place (State or Foreign ntry) nsylvania
13-00.30 72 hours after deeth with the Maryland "nature!", or ttame 23e or 28e-f ehow safeal Exemiliar must be notified at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		1	10d. Inside City Limits 1⊈ Yes 2 □ No
e Ma	9	MD Harford	Havre de C	Grace			
n th	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Coul	ntry?
h wi		143 Weber Street		21078		U.S.A.	
deet	Funeral	11. Marital Status 12. Was I	Decedent Ever in U.S. 13.1 d Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
after of	교		es 2 No	1 ☐ Yes 2 ☑ No Specify:			
3 si	þ	3 ☐ Widowed 4 12 Divorced Year	or Dates: 1941-1971	Tes 20110 Specify.		Specify: Whit	e
2-UUSO 72 hours after naturel, or its	Completed	15. Decedent's Education		dent's Usual Occupation kind of work done during most of work	10	3b. Kind of Business/In	dustry
	P e	(Specify only highest grade completed in the complete state of the	life.	DO NOT use retired)		T.C. Aremyz	
T pie d	ē	12	MI	litary		J.S. Army	
filed Hygin other	0	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Mi	aiden Sumame)	
d be ental	To B	Valentine Stefaniak		Valeria	Leniarte	ek	
Tarytar 2 should be and Menta 6 marked aumatic ex	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailii	ng Address (Street and Number or Rur	al Route Number,	City or Town, State, Zip	o Code)
M2 d 2 d th ar that trau		David Stefaniak (Son	4599	Massillon Rd. No	rth Canto	on. OH 447	720
IOTC, MATYIANG ZIZ ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If flam 27 fe merked other then or other traumatic event, the		20a. Method of Disposition				C. Location - City or T	own, State
or or or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal for	rom State 1		07	clington, V	7irainia
LIET L' Pa tmer tent		4 Donation 5 Other (Specify)					лідша
DESILITION  Permit. Page Department o Importent: If any njury or	9	21. Signature of Funeral Service (Icensee	100	larring-Cargo Fune	ral Home	P.A.	
4 40540	7	LWKHANI		Aberdeen, Maryland			
		23a. Part1. Enter the diseas , or formal ations the shock, or heart failure. List only one cause	nat ed the death. Do not ent on each line.	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician	3	Immediate Cause (Final disease or condition	Cardioo	Womanary An	rest	Topper	Oriset and Double
/Medica		resulting in death)	to (or as a consequence of):	ulmonary An Uyocardial In y Artery Di			
Examine	r		Acute 1	Uyorardial In	Carctio	n	2 days
	ē	Sequentially list conditions, if any, leading to immediate	to (or as a consequence of):	07000000			2 days
الله الله الله الله الله الله الله الله	声	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	Comman	u Artery Di	sease-		10 years.
exector and and all-tra	Examiner	resulting in death) Last Due	to (or as a consequence of):				
e be executed sicien and e burial-transit	E						
<b>BOX 06</b> (leath certificate attending physical for use as the	뜋						
Certii ding	Physician/Medi	IF FEMALE: 23c. If yes	, outcome of pregnancy			23d. Date of deliv	rery
BOX eath cer attendir for use	ä	in the past 12 months?	ive birth 2 ☐ Fetel death 3 ☐	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
hed bed	ys <sub>ic</sub>		Inknown				
Ords, P.O. BOX 08/ requires that the death certificate seen signed by the attending phys hould be detached for use as the		Part II. Other significant conditions contributing	to death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	acco use contribute to t	the cause of death?
VICAL MECOTOS, Icien: The law requires t certificate hes been signe ector, page 2 should be	ð	Severe Dement			1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
w require been si should?	iệ (	SCHE DEMEN	1111				
2 s t	Completed				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
VICAL MEDILICION: The laving certificete hes rector, page 2	Ę				perform 1 ☐ Yes 2	ed2 death? No 1 ☐ Yes	2□ No
rtiffice	0	25. Was case referred to medical		26. Place of Dea	th (Check only one		
ysic ysic is ce	9	examiner? 1 Tes 2 No Hospital:	1 Inpatient 2 ☐ ER/Outpatie	nt 3□ DOA Other: 4□ Nursing Ho	ome 5 Resider	ice 6 Other (Speci	fy)
g P g	ä		Date of Injury 28b. Time of Month, Day Year) Injury		28d. Describe how		
a fun	읥	1 Natural 5 Pending ( 2 Accident investigation	indiy	M 1 Yes 2 No			
JIVISION  for Attending efter death.  Director: After lin by the fune	100	3 Suicide 6 Could not be 28e. F	Place of Injury - At home, farm, st	reet, factory, office	28f. Location (Str. City or Town,	et and Number or Rur	ral Route Number,
die fe	Certification:	4 Homicide	ouilding, etc." (Specify)		City of Yours,	State)	
DIVISION OF VITAL ME TO THE HOSPITE OF TO THE HOSPITE OF THE MINIO 24 hours effer death.  To the Funsrel Director: After this certificate he completely filled in by the funeral director, page	edical C	(Check only 2 Medical Examiner: On t	the best of my knowledge, deat be basis of examination and/or in manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
the Thin 2 mple	Med	29b. Signature and title of certifier	THE STOREST	29c. License number	29	d. Date signed (Month)	. Day, Year)
F 2 5 8			, rug		-	July 3, 2	2007
L		-		- 1 0005 10 (			
84		Senjame and address of person who completed Benjamen Lee, MD	cause of death (Item 23a) (Type, G69 Revolution	on St. Harm	e de G	race, MD	21078
5	tate	Dr. Day (Marth Day Year)	32. Registrar's Signature			<u> </u>	
Regis	attell	1111 1 0 2007	Mague . la la	STATE!			

			For State Registrar	State of Mar	ryland /		rtment c			d Menta	, ,	ene g. No.	200-	7 2016
V.	Physici	an	1. Decedent's Name (First, Middle, Las	,						Mor		Day	Year	3. Time of Death
	/Medic		Etta Louise Schis				4b. City, Tov	vn, or Loc	cation of De	J <i>U:</i>	ve :	4c. C	ounty of Death	21:13
	Examili	CI	PENINSULA REGIONAL	medical Co	nter		5	alisba	114			1	Viamio	d
. 0	Funeral Director		5. Social Security Number 6. Social Security Number 216–30–8733		(In yrs. last 81	<i>birthd</i> ay) Yrs.	If Under 1 Y Months Da		Under 24 H lours N	lin. (Mo	of Birth nth, Day, 1		Соц	place <i>(Stat</i> e or Foreign intry) yland
	w .		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation							10d. Inside City Limits
	Maryl: f sho ied at	tor	MD Wicomic		Sa1	isbur	W							1 □Yes 2X No
	r 28a-	Director	10e. Street and Number	<u> </u>	Dai	.13041	10f. Zip Co	de			10	g. Citize	en of What Cou	intry?
	th wit		27905 Ocean Gatew	ay			218	801				US	A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at Once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			Vas Decedent Yes, specify □Yes 2X		nic Origin? Mexican, Pu pecify:	(Specify Yes uerto Rican, e	s or No- etc.)		I. Race - Ameri Black, White Specify: Whi	, etc.
1215-0036	ithin 72 houne. ne. han "natura e Medical E	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	de completed)  College (1-4or 5+	- 44	(Give life. E	ent's Usual O kind of work d OO NOT use n	lone durir	n ng most of	working			d of Business/Ir	ndustry
121	lled w Hygier her th	Co	12 17. Father's Name ( <i>First, Middle, Last</i> )	4+		$T\epsilon$	acher	18	Mother's I	Name (First,			cation_	
Maryland 21	d be fi ental h ced ot	Be c	L. Carroll Hopkin	c						ra Tayl		anden o	umame	
3	shoul nd Me mark	2	19a. Informant's Name/Relationship (7			19b. Mailin	g Address (St					City or	Town, State, Zi	ip Code)
Ĕ	and 2 palth a n 27 ls		D. Phyllis Schisl	er – daugh	ter	7706	Hennep	in C	Court,	, Hanov	ær,	Mar	yland 2	1076
altimore,	jes 1 a of He or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place	e of Disponence	sition (Name of natory or othe	of r place)		Date	2	0c. Loc	ation - City or T	own, State
<u>=</u>	t. Pag tment tant:		4 Donation 5 Other (Specify	)	Wicom									Maryland
Ba	Depa Impo any ir once.		21. Signature of Funeral Service Licen	y Block	2	70		lain	Stree	et, Sal	lisbu	ry,		nd 21804
8760,	Physician /Medical Examiner physician and physician ithe prival-itansit	al Examiner	23a. Fant. Enter the disease, or constitution of the shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c. Due to (or as a Due to (or a) Due to (	Mg( consequent S/ Insequen	fac (	reference of	f dying, s	uch as car	diac or respir.	atory arres	st,		Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal de	eath 3	Ectopic pregr					23	3d. Date of deliv	very Day Year
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions of	ontributing to death but	not resultin	ng in the ur	derlying caus	e given ir	n Part I.	236	e. Did toba			the cause of death?
Vital Records,		Completed								_	a. Was an autopsy perform ] Yes 2	/	24b. Were aut prior to co death? 1 ☐ Yes	topsy findings available ompletion of cause of 2 ☐ No
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Other:		Death (Check				
ō	Phys er this eral dii	٠ <u>.</u>	1 Yes 2 No	28a. Date of Injury	28	Bb. Time of	1 3 □ DOA 28c.	Injury at Work?	4 □ Nursir		Resider scribe how		Other (Spec	ify)
Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification of the funeral director, and the funeral director, the funeral director, the funeral director, the funeral director, and the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injur	y - At home	Injury e, farm, str	М	1 ☐ Yes	2 □ No	28f. Loc	ation (Stre	eet and		ral Route Number,
ā	pital or ours afte eral Dir filled in b		4   Hornicide	building, etc.  ysician: To the best of		edge, death	occurred at t	the time.	date and n		or Town,		and manner as	stated
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)	niner: On the basis of a	examination	n and/or in	estigation, in	my opini	on, death	occurred at th	e time, da	ite and	place, and due	to the cause(s)
)	P ₹ P 8	-	29b. Signature and tiple of Artifler	list"			He	505	936	8	29	0-	22 -6	2007
1	10		30. Name and address of person who	w/ V13	ioli	Ba) (Type,	o E.	Car	roll	56.	Sall	sho	ryn	stated. to the cause(s)  7, Day, Year)  2007  21504
	Sta Registi		31. Date filed (Month, Day, Year)  JUN 2 2 2	32. Registrar	rs Signatur	e	mate)						1	
DH	MH 17 Rev 1/2	001				1	- 3111							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a, c, 25 per me, 8871, 09/05/07dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** KJELGAARD Month Year 2119 PM AR STRAW HORN 20 07 "/Medical 4b. City, Town, or Location of Death
Westminster 4c. County of Death Carroll 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Hospital Center 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day) **Funeral** Months Days Hours 90 1 □ M 2 🛛 F Yrs. Director 220-30-5816 Usual Residence of Decedent July 30 1916 PA 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1X Yes 2X No Westminster MD Carroll Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 s marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 250 St. Luke Circle USA Funeral 21158 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Tate Bayard Kjelgaard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 910 Countryside Ct., McLean, VA 22102 John Martin Strawhorn/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Carroll Cremation, Inc 6/25/2007 Hampstead, MD 4 □ Donation 5 □ Other (Specify) 22Printer of Transmit Home and Chapel, P.A. 21. Signature of Funeral Service Ligensee 412 Washington Road Westminster, MD 21157 23a. Fart1. En ... r the disease, or complication shock, or heart failure. List only one care arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theumohia suivation **Physician** /Medical Due to or as a consequence of): APPROVIDED MEDICAL EXAMINER Examiner Dreis Bode Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Esophageal Strictures/Ulcers death certificate be executed burial-transi and Due to (or as a consequence of): physician s the burial Box 68760. CERTIFICAT Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown pege 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 **3** √No 2-1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 \Bull Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27, Manner 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred eath Certification: or Attending (Month, Day Year) 1 Vatural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 039502 MV MS and address of person who completed cause of death (Item 23a) (Type, Print) 30. Nam 10 BALT OSAIL MS ca 32. Registrar's Signature 31. Date filed (Month, Day, State Registra

Amended Item 10d per F.D. 06/26/2007 Carroll County, wjl

			For State Registrar	State of	Marylan		artment of F		and M	ental Hy	giene Reg. No.	2007	221	60
			Decedent's Name (First, Mia	dle, Last)						2. Date of De	eath	and the same	3. Time of D	eath
	Physic /Medi		Lucille Rebe	cca Shaffer	:					June	24	2007	3:55	$a^{M}$
	Exami		4a. Facility Name (If not institut	ion, give street and nun	nber)		4b. City, Town, o	r Location o	of Death		4c.	County of Deat	h	
		<b>A</b>	Sun Valley As					ninste				Carro		
ò	Funeral Director		5. Social Security Number 219–20–0047	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs. I	.,	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month, Da April	17,	9. Bird Co	hplace (State or buntry)  MD	Foreign
	and		Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. City	y, Town or Lo	ecation						10d. Inside City	Limits
	Maryl f sho	Ď	MD Ca	rroll		Most	minster						1 □Yes 2	2 <b>X</b> Vo
	r 28a	Funeral Director	10e. Street and Number	LIOII	I	West	10f. Zip Code				10g. Citi	izen of What Co	untry?	
	h with	a D	1820 Stone Ch	apel Road			21	L157				USA		
	deat ems 2	ner	11. Marital Status		dent Ever in U.	S. 13.	Was Decedent of H	Hispanic Ori	igin? (Spe	cify Yes or No	D-	14. Race - Ame Black, Whit		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. "natural", or Items 23a or 28a-f show or other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fu	1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce	arried 1 ☐ Yes If Yes, Giv	2 <b>X</b> No e		1 ☐ Yes 2 XNo	Specify:		ticari, etc.)			White	
5-0	72 hc 'natu dical	etec		ent's Education nest grade completed)		(Give	dent's Usual Occup kind of work done	durina mos	t of workin	ng	16b. Ki	ind of Business/	Industry	
121	12 should be filed within in and Mental Hygiene. 7 is marked other than "rearmatic event, the Mec	ם	Elementary/Secondary (0-12		-4or 5+)	life.	DO NOT use retire	d) -			Dor	Ton Cond		Trace
	iled v Hygie ther t nt, th	ပိ	17. Father's Name (First, Middle	e Last)		Frec	trical Te			(First, Middle			roller,	
Maryland	d be f ental l ed or	Be c	Thomas Warner	0, 2001)						Ecker	,	ourname,		
<u></u>	should Me mark	은	19a. Informant's Name/Relatio	nship (Type, Print)		19b. Maili	ng Address (Street	and Numb	er or Rura	I Route Numb	per, City o	or Town, State, 2	Zip Code)	
M	nd 2 salth au		Thomas Shaffe	r/son			6 Ridge R						_	
ē	s 1 a of Hea item		20a. Method of Disposition			lace of Dispo	sition (Name of matory or other pla			<b>7</b> 2007		ocation - City or	<u> </u>	
Ë	Page nent c int: if		1 □ <b>X</b> urial 2 □ Cremation 4 □ Donation 5 □ Other				n Memoria		dens		Fir	nksburg,	, MD	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau		21. Signature of Suneral Service	be Licensep			ritts Fun 12 Washin						21157	
	75.55		23a. P 11. Enter the sease,	or complications that c	aused the death							Ser's IND	Approximate Interval Between	
	Physician		shock, or heart failure. L	storily one cause on e.	ach line.		Sepsi	5					Onset and De	eath
	/Medical		disease or condition resulting in death)	a Due to (	or as a consequ	uence of):							73	
	Examiner		On somethally that a small than a	b										
-3	p ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a consequ	uence of):							<del></del>	
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С										
8760,	e execian a	Ě	resulting in death) Last	Due to (	or as a consequ	uence of):							ì	
87	icate be executed physician and s the burial-transit	dical		d										
9 X	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transitions.	Physician/Me	IF FEMALE:	23c. If yes, out	come of pregna	ancy			·			Old Data of dal	lh to = t	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregnanc	У				23d. Date of del Month		ear
0	that the died by the detached	ıysi	1 □ Yes 2 ☑ No 9 □ Unknown	9☐Unkno										
О,	res that igned b		Part II. Other significant cond	itions contributing to de	ath but not resu	ulting in the u	nderlying cause giv	ven in Part I		23e. Did	tobacco ι	use contribute to	the cause of de	ath?
rds	quires in sign	ed by								1 🗆	Yes 2	No 3□ P	robably 4 □Ur	ıknown
Records,	aw requir s been s	Completed								24a. Was		24b. Were au	utopsy findings av	vailable
R	The lav	mo								auto perf 1□ Yes	opsy ormed? 2 ☑ No	death?	completion of cau 2 ☐ No	use of
Vital	ian: ertifica ctor, p	Be C	25. Was case referred to medie examiner?	cal				26. Place	of Death	(Check only			2010	
or V	Physician: r this certific ral director,	10.	1 Yes 2 No			ER/Outpatie	nt 3□ DOA Oth	442 NL	ursing Hon	ne 5□Res	idence	6 □Other (Spe	cify)	
u c	Ing P		27. Manner of Death 1 ■ Natural 5 ■ Pend	28a. Date of (Mont	of Injury h, Day Year)	28b. Time o Injury	Wor			8d. Describe	how injur	ry occurred		
Sio	Attending r death. ector: After by the fune	cati		stigation	(1.1			Yes 2			· ·			
Division	Ital or Attencrs after deathral Director:	Certification:		rmined 28e. Place building	of injury - At hong, etc. (Specify	ome, farm, sti	reet, factory, office		2	8f. Location ( City or To	Street an wn, State	nd Number or Ri	ural Route Numb	er,
	To the Hospital or Attending Physician: The lwithin 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 ☐ Certification (Check only one)	ving Physician: To the al Examiner: On the ba and mann	asis of examina	wledge, deat tion and/or ir	h occurred at the ti	ime, date ar opinion, dea	nd place, a ath occurre	and due to the	cause(s)	) and manner as d place, and due	s stated. e to the cause(s)	
	To the within to the community of the co	Ž	29b. Signature and title of certi	Fler	usel N	<b>\</b>	29c. Licens		047		29d. Da	te signed (Mont	h, Day, Year)	
	1152			Joine 9	, ,,		2	0059	' ' ' >			june 2	5,200)	
	W-10		30. Name and address of person	n who completed caus	e of death (Item	23a) (Type,	Print)		20 0	0	0 5	has vaid	2/.0107	135
			) Snn (	- I sel Mo	295	>4n	en Im	5 V	143	6)	( )	1 min)	A WEST	(() /
	Sta Regist		31. Date filed (Month, Day, Yea	32. R	egistrars Signa	uure L	1 .							
DI	IMH 17 Rev 1/2		JUN	O COUN	Kalve	A	Grank	•						
5		-501												

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Donald Lee Shirley I 2007 0516 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 1942 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 65 GOHD(V) 218-40-2801 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Washington MD Big Pool 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10932 Big Pool Road 21711 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married white 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cement Co. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 12th grade 18. Mother's Name (First, Middle, Maiden Surname) Catherine Belle Weller 17. Father's Name (First, Middle, Last) Frederick Ralph Shirley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10932 Big Pool Rd. Big Pool, MD 21711 19a. Informant's Name/Relationship (Type. Print) Robin R. Shirley wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Shanktown Cemetery June 26 20a. Method of Disposition 20c. Location - City or Town, State Big Pool, MD 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia infarction Due to (or as a consequence of) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery nani 3 ☐ Ectopic pregnancy Month Day Year ths? 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work?

Physician /Medical **Examiner** 

Examiner

Physician/Medical

9

Completed

Be

Certification: To

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filled in by the

To the Hospital within 24 hours at To the Funeral C

Physician

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Marked

Baltimore, Maryland 21215-0036

and attending physician for 1 ed by the a detached f been signed by should be detac has

The law requires that the death certificate be executed certificate Hospital or Attending Physician: ' 44 hours after death. Funeral Director: After this certifica

Division or Vital Records, P.O. Box 68760,

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

and manner stated.

29c. License number

ss of person who completed suse of death (Item 23a) (Type, Print) 0

State Registrar

05H-6

JUN 27

5 Pending investigation

6 ☐ Could not be determined

32. Registrar's Signature

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For Stata Registrar	State of Ma	aryland i	-	rtment o tificate d				giene Reg. No.	2007	22171
	Physici	on	Decedent's Name (First, Middle, Last)		-		-			2. Date of De Month		Year	3. Time of Death
	/Medic			11ivan						June	12		2:25 A M
0.	Examir	ner	4a. Fecility Name (If not institution, give si	reet and number)			4b. City, Tow		on of Death	1		County of Death	101
	Funeral		349 Epping Way  5. Social Security Number 6. Sex	7. Age	e (In yrs. last	birthday)	If Under 1 Ye		der 24 Hrs.	8. Date of Bir			place (State or Foreign
	Funeral Director			M 2□F 78		Yrs.	Months Da	ys Hou	rs Min.	12/18/1	928	Cou	ginia
	pu »		Usuel Residence of Decedent  10a. State 10b. County		10c. City, T								I0d. Inside City Limits
	anyla ehov	ក	VA Lancaste	r	Seno		atton						1 ☐ Yes 22 No
	28a-1	rect	10e. Street and Number				10f, Zip Cod	le			10a, Citi	zen of What Cou	ntry?
	3a or	Funeral Director	841 Senora Road				2250				USA		,
	death	nerg	11. Marital Status	2. Was Decedent E Armed Forces?	Ever in U.S.	13. W	/as Decedent	of Hispanio	Origin? (S	pecify Yes or No o Rican, etc.)	-	14. Race - Americ Black, White.	
9	or its		1 Never Married 2 Married	1 ☐ Yes 2 🛣 N If Yes, Give	lo		☐ Yes XX			o rican, etc.)			nite
Ö	hours tural;	ed by	3 ☐ Widowed 4 📉 Xivorced	Year or Dates:	1	6a Doord	ent's Usual Oc	ounation			16h Ki	nd of Business/In	ducto
21215-0036	itled within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23a or 28a-f ehow int, the Madical Examinar must be mulliad at	Completed	(Specify only highest grade	completed)		(Give I	kind of work do O NOT use re	ne durina i	most of wor	king		Washingt	,
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ng		Be (	17. Father's Name (First, Middle, Last)							ne (First, Middle,			
<u>₹</u>	2 should be and Mental le marked o raumatic eve	2	James Robert Sulli			27				nkins Re			
Maryland	d 2 st th and 17 ie n traun	İ	19a. Informant's Name/Relationship (Type Deborah Hodges/dau	*	1					olis MD		r Town, State, Zij 1	Code)
	s 1 and 2 should of Heelth and Men item 27 is marks other traumatic		20a. Method of Disposition		20b. Place	e of Dispos	ition (Name o	,	, and a	Date		cation - City or To	own, State
Ê	Pages nent of int: If it		1 ☐ Burial 2 XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State			tan Cr		ry 6	/13/07	Ale	xandria	VA
Baltimore,	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service Licent	ilhelm						Cremati alls Chu			
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused	the death. [								Approximate Interval Between
ķ	Physician		fmmediate Cause (Final disease or condition	End(	tou	11	PART	1)15	PASE				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequen	ce of):	1110		01.55				
	Cxammer	٠.	Sequentially fist conditions, b.	Due to for so	#	1 N							years
	ted nsit	nine	Sequentially fist conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initions are only in the conditions of the	Due to (or as a	a consequent	Ce OI).							
~	execun n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	a consequen	ce of):							
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0		Med	IF FEMALE:										
X Q Q	requires that the death certific been signed by the attending p hould be deteched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of 1 ☐ Live birth	2 Fetal de	ath 3 🗌	Ectopic pregna				2	23d. Date of delive Month	ery Day Year
- -	the a	ysic	1 Yes 2 No	4 ☐ Pregnant at t 9 ☐ Unknown	time of death	n 5□	Other (specify	")					
ŗ.	that the de led by the a deteched f	/ Ph	Part II. Other significant conditions cont	ributing to death bu	ut not resultin	g in the un	derlying cause	given in P	art I.	23e. Did t	obacco u	se contribute to t	he cause of death?
g	w requires t been signe should be	d by								100	rés 2[	□No 3□ Prob	oabfy 4 Unknown
Hecords		Completed								24a. Was		24b. Were auto	psy findings available
ř	o	mo									rmed?	death?	mpfetion of cause of 2□ No
Vital	ystcien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?						lace of Dea	th (Check only o		C.	din
6	Physicien: this certific ral director,	2	1 Yes 2 No	spital:		Outpatient	3 DOA		Nursing H	ome 5 Resi		Other pecil	non (1
	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	b. Time of Injury		njury at Work? I ☐ Yes 2	2 □No	28d. Describe	iow irijur	y occurred	
NSI N	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ıry - At home	, farm, stre						d Number or Rura	al Route Number,
2	rs afte	Certification:		building, etc.	(эрөспу)					City or To	vn, State,		
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edicai	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examina	er: On the basis of	examination	dge, death and/or inv	occurred at the	e time, date ny opinion,	and place death occu	and due to the red at the time,	date and	and manner as s place, and due to	tated. o the cause(s)
	within 2 To the complet	Med	29b. Signature and title of certifier	and manner stat	Led.			ense numb				e signed (Month,	
	⊢s⊢ŏ		Panial.	1 Act	ONA	ZIM		1) 1	11/2	38	5	hune	2/07
			30. Name and address of person who on	of ed cause of de	eath (Item 23	la) (Type, F	Print)	7	11	70	X		. 11 -
10	AH		MILMARJIL	atenin	MI	445	DEFE	NSE	H76	, HWAy	10	NAPUL	15 MD440
	Sta		31. Date filed (Month, Day, Year)		ur's Signature	k A	back o						

	1- For State of Maryland Registrar	Certificate of Death	Reg. No. 2007 2217					
Physician	1. Decedent's Name (First, Middle, Last)  Luther David Shaffer		2. Date of Death Month Day Year 6/20/2007 3:40 pM					
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  Spa Creek	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arunde1					
Funeral Director	5. Social Security Number 6. Sex 7. Age ( <i>in yrs. la</i> 204–26–6632 <b>XX</b> M 2□ F 71	ast birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month Day, Year) 9. Birthplace (State or Foreign PA) PA					
e Maryland Ra-f show tified at		nady Side	10d. Inside City Limits 1 □ Yes 2☐No					
th with the Mar 23a or 28a-f sl ist be notified	10e. Street and Number 4940 Lerch Dr.	10f. Zip Code 20764	10g. Citizen of What Country? USA					
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 57	If Yes specify Cuban Mexican Puerto	acify Yes or No-Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry					
ed within 72 hor ygiene. ygiene "natur: ter than "natur: t, the Medical E	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12	(Give kind of work done during most of work life. DO NOT use retired)  Salesman	Real Estate					
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than any injury or other traumatic event, the Monee.  To Be Comp	17. Father's Name (First, Middle, Last) Stanley M. Shaffer	18. Mother's Name Gladys K	e (First, Middle, Maiden Surname) Lane					
and 2 sho alth and 1 27 is ma	19a. Informant's Name/Relationship (Type. Print) Phyllis M. Shaffer Wife		al Route Number, City or Town, State, Zip Code)  y Side, MD 20764					
Pages 1 gnent of He int: If Item inty or oth	EMBURAL 2   Clemation 3   Hemoval from State	lace of Disposition (Name of emetery, crematory or other place)  green Cemetery 6/25/	200. Location - City or Town, State Harmonsburg, PA					
permit. Departm Importa any inju	21. Signature of Funeral Service Libensee	22. Name and Address of Facility Har	desty Funeral Home, P.A.					
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequ	LUNG Cancer	or respiratory arrest,  Approximate Interval Between Onset and Death 2					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	lence of):						
ficate be executed ficate be executed physician and is the burial-transit edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  C	ience of):						
= m = 0	IF FEMALE:							
The law requires that the death certificate has been signed by the attending age 2 should be detached for use as ompleted by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						
uires that the de	Part II. Other significant conditions contributing to death but not result	Ifficant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobac						
The law requir			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?					
	25. Was case referred to medical examiner?		1					
Physical direction To To To To To To To To To To To To To			me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
tending lasth. tor: After the funer	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	Injury Work? M 1 Yes 2 No						
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be C	4 Homicide determined building, etc. (Specify)	)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
he Hosp in 24 hou he Fune pletely fil	29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	wledge, death occurred at the time, date and place, ion and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)					
with Common South	29b. Signature and office of certifier  Allowed Library	29c. License number D19838	29d. Date signed (Month, Day, Year) G(20/2007)  10H Rel: Annopolis, Und					
200h	30. Name and address of person who completed cause of death (Item STVUV) E, SELOWICH,		ate Rel: Annapolis, Und					
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signate 32. Question 32. Registrar's Signate 33. Registrar's Signate 33. Registrar's Signate 33. Registrar's Signate 34. Reg	J. John						
DHMH 17 Rev 1/2001		ORIGINAL						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Effie Juanita Rucker Stephenson 23, 2007 June 7:06 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 13,1934 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 X F Yrs. 73 224-40-3261 Director Virginia Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Directo 1 XYes 2 □ No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 ral", or items 23a or ? Examiner must be r 4225 - 3rd Street, N. W. 20011 United States Funeral death death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify **Black** ģ Specify: 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Washington Hospital Elementary/Secondary (0-12) College (1-4or 5+) years **Nursing Assistant** Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd 2 should be fi lith and Mental H 27 is marked ot r traumatic ever (unknown) Mattie Bell Rucker Pages 1 and 2 should ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 (Son) if item 27 i Department of Health Important: if item 27 any injury or other tronce. Joseph McKinley Stephenson 17217 Brookmeadow Lane; Upper Marlboro, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 29,2007 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Anna Name and Address of Facility N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 2 months /Medical Due to (or as a consequence of): Examiner Diverticulas Abscess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗶 No Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been signated bage 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate 1☐ Yes Physician; 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. Records, Division or Vital

death. after death filled in by the Hospital

24 hours a within 2 B

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29c. License number D0064502

June 23, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.Brian, Carpenter, M.D.; 9901 Medical Center Drive; Rockville, Maryland 20850

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

and manner stated.

07-05054	
Jamont Thomas	

amont Thomas		State of Maryland / Department of Health and Mental Hygical Certificate of Death		2.0	07 221
Dhyminia		Registrar  1. Decedent's Name (First, Middle,Last) 2. D	ate of Deati		3. Time of Death
Physicia Iedical Examir	-	, and the state of	⁄lonth Jly 1, 200	Day Year )7	0930 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
		Aberdeen Proving Ground Aberdeen Proving Ground		Harford	
Funeral		Months Days Hours: Min		h(MM/DD/YYYY) 9. Bir Foreig	ın N.T. TE
Director		144-68-1967 1XM 2F 28 Yrs. World St. 144-68-1967	7/31/	78 6	untry) NJ
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
		MD Harford Havre de Grace			1 Yes 2 X No
Aaryland 28a-f show	ctor	10e. Street and Number 10f. Zip Code	_ 10	g. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho	Director	2028 Lori Ln. 21078		U.S.A.	
with th	- 1			14. Race - Amer White, etc.	ican Indian, Black,
death r iten	uneral			B1	ack
after	by F	3 Widowed 4 Divorced in the Given Feat or Dates:	-	Specify: 16b. Kind of Business/	
hours after natural", (Examiner		15. Decedent's Education (Specify only highest grade completed)	done ,	Top. Kind of Edsinessi	
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5-0036 led within 72 Hygiene. other than '	Com	17. Father's Name (First, Middle, Last)  18. Mother's Name (First	st, Middle, N	Maiden Surname)	
215 be file ntal Hy rked o	Be	Ramont G. Thomas Linda J. I			
21 ould l d Mer s mar	10	2 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural	Route Num	ber, City or Town, State	e, Zip Code)
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 and of Health and Menial Hygiene. It filtem 27 is marked other than "other traumatic event, the Medical		Rebecca A. Thomas (Spouse) 2028 Lori Ln. Havre de	e Grac	e MD 210	78 Town, State
ore, ME ss Land 2 st of Health at If item 27		1 x Burial 2 Cremation 3 Removal from State crematory or other place)			
imore Pages 1 ment of F tant: If i		4 Donation 5 Other Specify: Rosebank Cemetery 7/7/07		Rising Sur	The state of the s
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Aber  Tarring-Cargo Funeral	rdeen,	MD 21001	-3399
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res	spiratory arre	est, shock, or heart	Approximate Interval
/Medical		Tailure. List only the cause on each me.			Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)  a. Carbon Monoxide Toxicity  Due to (or as a consequence of):			
		Sequentially list conditions, b			
	Examiner	if any, leading to immediate Due to (or as a consequence of):			
	каш	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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	dical	AMENDED #23a,27,28a-f, perME,2870, 8/24/07 TT			L
SOX 68760, leath certificate be attending physic for use as the bu	/Me	IF FEMALE:  23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the  1 Live birth  2 Fetal death  3 Ectopic pregnancy		23d. Date of deliver Month	y Day Year
lox 68 eath certif	ciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
Box 68760 e death certificate be the attending physical for use as the bu	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	an mini		the source of death?
Division of Vital Records, P.O. Box 68760 within 24 hours after death. The taw requires that the death certificate to the Finneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the build the table of the same of the build by the same of the build by the funeral director, page 2 should be detached for use as the build by the funeral director, page 2 should be detached for use as the build by the funeral director, page 2 should be detached for use as the build by the funeral director, page 2 should be detached for use as the build by the funeral director.	by PI			bbacco use contribute to	
uires t			1 24a. Was		utopsy findings available
ords, aw requinas been as been 2 should	ompleted		autop		completion of cause of
Rec The la	mo;		1 Yes		es 2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seen in the top the funeral director, page 2 should be a be to be a seen in the funeral director, page 2 should be a seen in the funeral director, page 2 should be a seen in the funeral director, page 2 should be a seen in the funeral director, page 2 should be a seen in the funeral director.	Be C	25. Was case referred to medical examiner?		Residence 6 🗸 Othe	ar Soons
Physic rthis	10	1 Ves 2 No Imparent 2 Envoyagement 2		how injury occurred	er. Scene
n of ding Ph	on:			nose from exha	ust into car
Sio Atten r deatl ector	cati	2 Accident Survey Accident July 1, 2007 0935 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f.	f. Location (	Street and Number or R	ural Route Number, City
Divi	Certification:	3 X Suicide 6 Could not be determined (Specify) Aberdeen Proving Ground New	ar Bidg	g. 471, APG MD	21005
Divisior To the Hospital or Attend within 24 hours after death To the Finneral Director:			e to the caus	se(s) and manner as sta	ted.
thin 2 of the 1	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e time, date	and place, and due to t	ne cause(s)
F ≥ F 8	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Me	onth, Day, Year)
		Toll fraguer 31047036A In	idiana	July 2, 2007	
		(tom 22a)			1) same
		230. Name and address of person who completed datase of death (fem 20a)  Ladd A. Tremaine, MD OAFME / AFID 1413 Research B1	va x	LOCKVIlle P	1) 20850
St Regist	ate	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
<del>.</del>					
DHMH 17 Rev 1/20	บป1	ORIGINAL			

07-04976

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ANCO HEATIBE ate of Maryland / Department of Health and Mental Hygiene

arvin Bruce i nom	1950 1-1	or State Amend#4	b Per ME	7/5/07 C	MH C	ertifica	ate of l	Death			, , ,	Reg	. No	200	
Physician/	Re	Decedent's Name (First									I	Date of Death Month	Day Ye	ar 3.	Time of Death 0745 hrs
ledical Examine	3	Marvin Brud	ce Thom	pson							J	une 30, 20	4c. County	v of Death	07451115
	4a	. Facility Name (if not in		street and numb	oer)		46	. City, Town, Arbutus				<b>ــــــــــــــــــــــــــــــــــــ</b>		ore Count	y
	Ļ	4259 McDowell I		17	Age (in yr	s last hirt	hday)	If Under 1	Baut ear I If	f Under 2	2 H19 24Hrs. [8	hlands 3. Date of Birth	(MM/DD/YY)	(Y) 9. Birthp	lace (State or
Funeral Director	2	Social Security Number 12-84-9720	1X	M 2 F		48	Yrs.	Months [	$\overline{}$	Hours	Min.	6/14/		Foreign	ry) MD
ъ	-	sual Residence of Dece Da. State 10b. 0	County		10c. C	ity, Town	or Locatio	n							0d. Inside City Limits
ow any			•	County	. Ba	1tim	ore 1	Highla	nds					1	Yes 2 X No
Maryland 28a-f show d at once.	10	De. Street and Number	LCIMOIC					10f. Zip Coo				10	g. Citizen of \	What Country	y?
he Maryland to 128a-fsh iffed at once	4	259 McDowe	11 Lane	:					227			10	USA		
with t	1	1. Marital Status		12. Was Dece		n U.S.	13. Was	Decedent or s, specify Cu	Hispar	nic Origin lexican, P	? (Spec Puerto Ri	ify Yes or No- can, etc.)		ice - America hite, etc.	n Indian, Black,
r death with or items 23 must be no	5 1	Never Married 2		1 Yes	2 X N	0		Yes 2X					Specif	w. Whi	te
safter ral", onner	<u> </u>	Widowed 4  15. Decedent's Educati		If Yes, Give Year or Dates:	completed	i) 16a.	Decedent	's Usual Occ	upation	(Give kir	nd of wor	k done		Business/Ind	iustry
5-0036 ed within 72 hour: tygiene. other than "natu ne Medical Exan	<u> </u>	Elementary/Secondary		College (1-		-	during mo	st of working	ife. DO	O NOT us	se retired	1)	-	. 1 .	
hin 72 e. than edical	2	10					Mec	hanic							Bus Company
5-00 ed wit lygien of the M	5 1	7. Father's Name (First	, Middle, Last)									irst, Middle, N ise Sw		me)	
21215-0036 Suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	ן ם	illiam Tho	-	Dist.		T 10	h Mailing	Address (		-		ral Route Num		own, State,	Zip Code)
Baltimore, MD 21215-0036  pemir. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health 1st Morella Hygiene. Important: If item 71 is marked offer than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at once To Do Completed by Firmeral Director		9a. Informant's Name/F		Wife		5	518 Q	ueen A	nn .	Ave.	00	enton,	MD 21	113	
, MI and 2: ealth 2: em 27: traum	_	Oa. Method of Dispositi	on			0b. Place	of Dispos	tion (Name o	of cemer	tery,		Date	20c. Location	on - City or T	own, State
Ore ges la t of H		1 Burial 2 X C	remation 3		m State		atory or oth	matory	,		7/2	/2007	Balti	more,	MD
tim it. Pa urtmen ortant		Donation 5				.10.01.0	22. N	ame and Ad	dress of		Hard	lesty F	uneral	Home,	, P.A.
Ba Depri Imp	i	STA	1 /	1/(			12	Ridge	1y	Ave.	Ann	apolis	, MD 2	1401	Approximate Interval
Physician	1	23a. Part I. Enter the dis failure. List only or	ne cause on ea	ich iine.							rdiac or	respiratory arr	est, snock, or	neart	Between Onset and Death
ical aminer		Immediate Cause (Fina	I disease a.	Atheroso			diovas	<u>cular d</u>	iseas	se					
		or condition resulting in		Due to (or as a	consequer	ice of):									
	<u>-</u>	Sequentially list condition if any, leading to immediate	tiate	Due to (or as a	consequer	nce of):									
	티크	cause. Enter Underlyin (Disease or injury that i	nitiated	Due to (or as a	consequer	nce of):									
d ansit		events resulting in deat	(n) Last d	•											
Ox 68760, eath certificate be executed e attending physician and for use as the burial - transit	Medical	X UNPENDED		#25a,27	nerME.	o870	8/13/	2007 11	,					-8-6-	
'60, ate be		IF FEMALE:	nent in the	23c. If yes,	outcome of		у		2	Ectonic	pregnar	nev	23d. Dai Mon	te of delivery th D	Day Year
687 certific	ian	23b. Was decedent preg past 12 months?	gnam in the	1 Live b	irth ant at time	of death	_ =	etal death ther (Specif	y)	Lotopic	program	10,	1.		
Box 687 e death certific	Physician/	1 Yes 2 No 9										OO Did	tab a see use o	antributa ta	the cause of death?
cords, P.O. Bo aw requires that the de has been signed by the should be detached f		Part II. Other significa	nt conditions	contributing to	death but	not result	ting in the	underlying c	ause giv	ven in Pa	art 1.				pably 4 Unknown
ires that the signed by	od by	-										24a. Was		24b. Were au	topsy findings available
ords w requisites should	Set											auto		prior to death?	completion of cause of
Reck The lar	Completed										(0)		2 No	1 🗸 Ye	es 2 No
Division of Vital Records, tal or Attending Physician; The law requir ars after death.  The Director: After this certificate has been so led in by the funeral director, page 2 should be a sould be a	8	25. Was case referred examiner?	to medical	Hospital:		• 🗆 = =	/Outpatier		- 10	of Death Other		g Home 5	Residence	6 🗸 Other	r: Scene
of Vit	흔	1 ✓ Yes 2 27. Manner of Death	No	28a. Date	Inpatient of Injury		b. Time of			y at Work		28d. Describe			
n of \alpha oding Phy. h. After the funeral	ö	1 X Natural 5	Pending	(Monti	n, Day,Yeár)				1 Y	es 2	No				
ISIO Atten or deat rector by tho	icat	2 Accident	Investiga	28e, Plac	ce of Injury	- At home	e, farm, str	et, factory,	office bu	uilding, et	tc.	28f. Location or Town	(Street and N	lumber or Ru	ural Route Number, City
Divi	Certification:	3 Suicide 6 4 Homicide	Could no determin	ed (Specify,											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri-		One Contifier	ertifying Physi	cian: To the be	st of my kn	owledge, ation and/	death occ or investig	urred at the ation, in my	time, da opinion,	ite and pla , death o	ace, and ccurred a	due to the ca at the time, da	use(s) and m te and place,	anner as stat and due to th	ted. ne cause(s)
To the To the comp	Medical	29b. Signature and titl		and manner	stated.					e number			29d. Date	signed (Mo	onth, Day, Year)
	_	11044	- 1	No MC	all				O.C.1	M.E.			July 1,	2007	
		30. Name and addes	s of person wh	o completed car	use of deat	h (Item 23	Ba)			- 147	- 145	04004			
4 CH		Margarita Kor	ell MD.	Assistant Me	edical Ex	aminer	111	Penn Stre	et, Ba	altimor	e, IVID	21201			
St Regist	ate trar	31. Date filed (Month,		007	egistrar's	orgriature		and of	Ш						
DHMH 17 Rev 1/2		- 30	1 00.		-		ORIGIN	AL							DOME

			For State Registrar	State of Marylar			f Health ar of Death	-	giene Reg. No.	***	22176
			Decedent's Name (First, Middle, Las	1)				2. Date of Dea	ath	· ·	3. Time of Death
	Physici		FRITZ RICHARD VO	TEL				JUNE	21,	2007	6:00P M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of I	Death	4c. County	of Death	
			FORESTVILLE NURS	NG AND REHAB		FC	RESTVILI	LE	PR	INCE	GEORGES
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Ye Months Da		Hrs. 8. Date of Birt Min. (Month, Da	h v. Year)	9. Birthp Coun	ace (State or Foreign
	Director		5// 48 3618	<b>X</b> M 2□F	95 Yrs.	INOTICIS DO	110013	OCT/ 04	, 1911		MANY
-	pur *		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty. Town or Lo	cation				1	Od. Inside City Limits
	sho	ò								l'	TXOXYes 2 □ No
	ith the Marylar or 28a-f show	ect	MD PRINCE (	GEORGES CA	APITOL	HEIGHTS			10g. Citizen of	Mhat Coun	
	a or	급									,
	eath wi	eral	1808 ARCADIA AVEN	12. Was Decedent Ever in U	IS 13 V	207		2 (Specify Yes or No.	UNITE	e - Americ	
10	iter d	Funeral Director	1 Never Married XXMarried	Armed Forces? XIX Yes 2 □ No	i	f Yes, specify C	Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	Bla	ck, White,	
036	ours after death with the Maryla ral', or Itams 23a or 28a-f shov Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡ Yes 2 <b>X</b> OX	No Specify:		Specif	v: WHI'	ΓE
21215-0036	n 72 hours after death with the Maryland "natural", or Itams 23s or 28s-f show silical Examiner must be notified at	Completed	15. Decedent's Ed		16a. Deced	dent's Usual Oc	cupation one during most o	d working	16b. Kind of B	usiness/Inc	lustry
21	within 7 ene. than "r	nple	(Specify only highest grades) Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use re	tired)	r working			
	ifiled within Hygiene. other then rent, Ine Ma	Con	12TH		MUSI	CIAN			U.S. M		CORPS
nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumar	ne)	
yla	2 should be and Mental Is markad or raumatic ave	<sup>2</sup>	RICHARD GUIDO VOI				- '	SEIFERT			
Maryland	12 sh and Is m		19a. Informant's Name/Relationship (7	ype, Print)		,		or Rural Route Numbe			
	as 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. I itam 27 is markad othar than "natur r othar traumatic avent, Ita Madical		MARJORIE MAY VOIT  20a. Method of Disposition		_	ARCAD I sition (Name of	A AVENUI	E CAPITOL Date	HEIGHT:	-	
Baltimore,	m O		1 ☐ Burial 2XXCremation 3 ☐	Removal from State	cemetery, cren	natory`or other	place)			•	
Itin	permit. Page Department of Important: If any injury or once.		<ul><li>'4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service License</li></ul>	11111				06/26/2007_	ALEXA		
Ba	permit. Page Department ( Important: If any injury or once.		21. Signature of Pulleral Service Licens	0 11	22	MARSHA	LL'S FUN	NERAL HOME	OF MAR	YLAND	INC.
			23a. Party Enter the disease, or comp	lications that caused the deat	th. Do not ent			ROAD SUIT		3 207	46 Approximate
. 6			23a. Paril Enter the disease, or composition, or heart failure. List only of Immediate Cause (Final				-,g,	,,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aCARDIOPULMO		AILURE					
	Examiner			Due to (or as a consect  CORONARY AR		TCEACE					
		je.	Sequentially list conditions, if any, leading to indirections cause. Enter Underlying Cause (Disease or injury	b. CURCHART AN		ISEASE					
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	aTHEROSCLER	OTIC C	ARDIOVA	SCULAR I	DISEASE			
ó	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a conseq	quence of):						
8760,	ate be nysici he bu	dical		d							
		Med	IF FEMALE:								
Вох	death certifi e attending I d for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	al death 3	Ectopic pregna				te of delive	ry Day Year
0.	that the death certifi ed by the attending detached for use as	Physician/Me	1 Yes 2 No	4□Pregnant at time of d 9□Unknown	death 5	Other (specify	")				
Θ.	hat thad by	Ph	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause	given in Part I	23e. Did to	obacco usa con	tribute to th	e cause of death?
Records,	Se G	d by	DEMENTIA		, , , , , , , , , , , , , , , , , , ,	idony ing dabad	giroitaita				ably XX Unknown
Ö	- 0 10	Completed						-		Mara auto	findless sudlable
Rec	The law r ate has be page 2 sh	ld m						24a. Was autop	sy	prior to cor death?	psy findings available apletion of cause of
_	n: Th ficate nr, pa		05 18/00 0000 19/0000 18 10 10 10 10 10 10 10 10 10 10 10 10 10					1 Tes	ØX□ No	1 🗆 Yes	2 🗆 No
Vital	Phyaician: The law this certificate has braidirector, page 2 s	o Be	25. Was case referred to medical examiner?  1 ☐ Yes XX No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA		f Death <i>(Check only o</i> ing Home 5 ☐ Resid		/C	A
	_ = E	0; To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. I	njury at	28d. Describe h			)
ion	Attanding I r death. actor: After by the funer	atlo	1XXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Infury		Work? 1 □ Yes 2 □ No				
Division	or Attandii after death. Diractor: A in by the fu	Iffici	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of tnjury - At h	ome, farm, str	eet, factory, offi	ice	28f. Location (S City or Tox		oer or Rura	Route Number,
Ō	tal or A s after al Dirac ed in by	Certification;		building, etc. (Opecin	977			only of You	n, olalo,		
	To tha Hospital or Attan within 24 hours after deat To tha Funaral Diractor: completely filled in by the	cal	29a. Certifier (Check only 2 Medicel Exam	rsician: To the best of my kno iner: On the basis of examina	owledge, death	occurred at th	e time, date and p	place, and due to the	cause(s) and ma	anner as st	ated.
	To tha H within 24 To tha F complete	Medical	one)	and manner stated.							
	To To Con	2	29b. Signature and title of certifier				ense number		29d. Date signe		
2			· Olvoor	ノ			51520		JUNE 2	, 200	)/
2	(5)		30. Name and address of person who o				A \$77733777	III			2.2
	0	7	BAHRAM PISHDAD, M	1. D. 1	328 SO	UTHERN	AVENUE S	SE WASHING	TON, DO	200	32
	Sta Registr		IUN 2 6 2007	32. Registrar's Sig	we						

law requires that the death certificate be executed or Vital Records, P.O. Box 68760, physician Physician; this After or Attending death. within 24 hours after deatl To the Funeral Director:

C3H-5+1

DHMH 17 Rev 1/2001

State Registra

31. Date filed (Month, Day, Year)

R. RIGGEF.

29b. Signature and title of certifier

medice 11110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAR CALLUCE, MO

32. Registrar's Signature JUN 28 2007

29c License number

038364

Rd

S.t. 127

29d, Date signed (Month, Day, Year)

			For State	State of Ma	ryland / Dep	artment of F rtificate of I			0000	7 00176		
	_		Registrar  1. Decedent's Name (First, Middle, La	o#)		rinicale or i		2. Date of Death	g. No. 🔏 📗	3. Time of Death		
	Physici	an		atson				Month June	Day 2007			
	/Medic		4a. Facility Name (If not institution, giv			4h City Town or	r Location of Death		4c. County of Dea			
hi.	Examin	er	45 Kensington Dri			Easton	LOCATION OF DEAT		Talbot	ui		
16	Funeral		5. Social Security Number 6. S		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	thplace (State or Foreign			
h	Funeral Director			<b>⊠</b> M 2□F	73 Yrs.	Months Days	Hours Min.	1071971	933 Ma	aryland		
	contact of the		Usual Residence of Decedent									
	ylan how at		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. inside City Limits		
	a-f s	cto	MD Talbot		Easton					1 ☐ Yes 🎘 🛣 No		
	be filed within 72 hours after death with the Maryland that lygiene.  d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	al Director	10e. Street and Number 45 Kensington Dr.			10f. Zip Code	21601	109	g. Citizen of What Co USA	ountry?		
	deat ms 2	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whi			
9	after or ite	F	1 ☐ Never Married 2 Married	1 Tyes 2 X N	lo	1 ☐ Yes 2 ☑ No	Specify:	o riican, etc.)		Nhite		
215-0036	ours iral", Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		12 100 22 10	Opcony.		Зреспу.			
5-(	72 h 'natu dical	Completed	15. Decedent's Ed (Specify only highest gra		ı (Give	dent's Usual Occup kind of work done	during most of wor	rking	6b. Kind of Business	/Industry		
121	/ithin ne. han e e Me	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired	1)					
21	led w lygiel her tl		47 Fallenda Nama (Final Middle Land	11		Sales	40. Mathada Nas		anking Equ	ıipment		
no	d d o	The state of the s										
7	I Mer											
Maryland	12 sh h and h is π rauπ		19a. Informant's Name/Relationship ( Naomi Frances Wat		1	,			, , , ,	Zip Code)		
	ss 1 and 3 of Health item 27			SON WII	20b. Place of Dispo		Drive :	Easton, M		T Ot-t-		
0	S ← ± 0		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	matory or other plac	· · · · · · · · · · · · · · · · · · ·	-	0c. Location - City or			
Ë	: Ра tmen tant: jury		4 ☐ Donation 5 ☐ Other (Special		Baldwin (	-	, ,	5/2007	Millersvi			
Baltimore,	permit. Pages Department of Important: If i any Injury or once,		21. Signature of Funeral Service Lices	nsee				•	uneral Hor	ne, P.A.		
			mapu		1		-	nnapolis,	-			
	Physician		23a. Fart1. Enter the divease, or com ho k, or hear fa ure. List only Immediate Cause (Fir I disease or condition	plications at caused one caus each lir	the death. Do not en	ter the mode of dyir	ng, such as cardiae	or respiratory arres	st,	Approximate Interval Between Onset and Death		
	/Medical		resulting in death)	Due to (or as	a consequence of):	,						
ĸ.	Examiner		Sequentially list conditions.	b								
	P #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):							
	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	c								
30,	e existan sian surial-		resulting in death) East	Due to (or as	a consequence of):							
8760,	ate b hysic the b	lica		d								
9	ertific ing p	Med	IF FEMALE:									
Вох	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3[	□Ectopic pregnancy	/		23d. Date of de Month	livery Day Year		
. E	e dea	sici	1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			Worth	Day Teal		
P.0	at the	hy.	9 ☐ Unknown									
Ś	ires that the de signed by the a be detached t		Part II. Other significant conditions	contributing to death bu	it not resulting in the u	inderlying cause giv	en in Part I.			o the cause of death?		
ord	w require been sig should b	bed .						1 ☐ Yes	3	robably 4 Unknown		
Records,	law as b 2 s	Completed by						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of		
æ	The ate h page	E O						perform 1∐ Yes 2	ed? death?	2 □ No		
Vital	sician: The certificate ha rector, page	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one,	)			
>	S O TO	To	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3□ DOA Oth	er: 4  Nursing H	lome 5 Residen	nce 6 □Other (Spe	ecify)		
	ding Ph h. After thi funeral		27. Mannor of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	y 28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe hov	v injury occurred			
Division	endir ath. or: A	atic	2 ☐ Accident investigation	1			Yes 2 □ No	=				
Ξ	er de irecto	titic	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of inju	ry - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:		8			J		<u> </u>			
	hour hour			nysician: To the best on miner: On the basis of								
	the H in 24 the F	Medical	one)	and manner sta								
	Vith Vith	Σ	29b. Signature and title encerifier	A		290 Licens	e number.	7 29	d. Date signed (Mon	th, Day, Year)		
	010					U.	1100		6/21	/ /		
\	DID,		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)			1	7		
	, the		Dr. David Smith,	MD 8221 Te	al Dr. Sui	te 302 I	Easton, N	D 21601				
2.1	Sta	ite	31. Date filed (Month, Day, Year)	2007 32. Figistra	ar's Signature	1	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month June **Physician** 2007 A M 16, 5:14 DANIEL E WALKER JR /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick
If Under 1 Year | If Under 24 Hrs. Frederick Birthplace (State or Foreign Country) Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 XM 2 □ F 130-30-9710 67 Director Mar. 4.1940 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Yes 2 No Director Roanoke VA Roanoke 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Montal Hygene. Important: If them 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be not pijury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not be a contracted to the U.S.A. 24017 NW Funeral 3116 Willow RD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after Hygiene. 1 □Xes 2 □ No 1963 − If Yes, Give Year or Dates: 1965 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) IBM Analyst 12th Pages 1 and 2 should be filed in ment of Health and Mental Hygis ant: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Calloway Jean Walker Daniel Ε. ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Willow Road, NW Roanoke, VA 24017 Marilyn Walker- Wife Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Riverdale Crem.Svs 6/21/07 kiverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home. PA 21. Signature of Funeral Service Licenses 246 N. Washington St Rockville ,MD20850 23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final e, or complications that caused the death List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Sepsis
ue to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner andidemio Sequentially list conditions, if any, leading to immediate cause. Each of John Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Acute Renal Failure 24a. Was an autopsy performed? 2 100 Hospital or Attending Physician; 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Mo Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Heigh Williams MD 00064741 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Williams

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Leigh

2007

32. Registrar's Signature

Frederick Memorial Hospital,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 24a per verb., 870,0713,07616 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Ella Wagner 6 07 May 5 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Medical SAlisbure NICOMICS enter Neglenal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 **Funeral** Days Hours 1 ☐ M 2 😿 F 216-40-4831 67 Maryland Director 2/3/1940 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 1022 Adams Ave., Apt. 3C by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within 7 Health and Mental Hygiene. em 27 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Shirt Factory 18. Mother's Name (First, Middle, Maiden Surname) injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be Henry M. Griffin Irma Pearl Donoway 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any injury or other trau 1022 Adams Ave., Apt.3C, Salisbury, MD 21804 Theresa Faye Hall/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/22/07 Hebron, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility Holloway Funeral Home Professional Association will 24 501 Snow Hill Rd., Salisbury, MD 21804 Chompoor Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LONCESTIVE LARPIO MYOTATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASLUVI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed the burial-trar and Due to (or as a consequence of): 68760 attending physician Physician/Medical as Box IF FEMALE: be detached for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9□Unknown 9 Unknown signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 1 ☐ Yes 2 ☐ No 3€ No 1∐ Yes Physiclan: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 TNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120912

Age

140

State Registrar UPAnis Chodnicki 31. Date filed (Month, Day, Year) JUN 2 2 2007

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St. Salisbury MD 2/80/ 32. Begistra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Vear PATSY ANNE WINSTON WARFIELD JUNE 2007 8:30A /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ARCOLA HEALTH AND REHABILIATATION SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M XX F Director 223 70 2972 JUNE 06, 1949 VIRĞINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow r than "natural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at 1 Yes XX No MD MONTGOMERY SILVER SPRING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3301 HAMPTON POINT DRIVE #A 20904 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after or 1 Never Married XX Married ☐ Yes 2XXNo Yes, Give 1 ☐ Yes XXNo Specify þ Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1YR. ACCOUNTING CLERK PRIVATE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be fil Health and Mental H tem 27 Is marked ott JOHN GEORGE WINSTON RUTH TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health as Important: If Item 27 Is any injury or other traus. CAMILLE R. WINSTON-WAID / DTR 4111 CARRIAGE DRIVE TEMPLE HILLS, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State XX Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) WASHINGTON NATIONAL CEM. 6/28/07 SUITLAND, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. Mans 4308 SUITLAND ROAD SUITLAND, MD 20746 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GLIOTSLASTOMA WITH METASTASES **Physician** MONTXS /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed tran and physician a Due to (or as a consequence of) Physician/Medical d as IF FFMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed' certificate 1 Yes 2 No 2 400 25. Was case referred to medical 26. Place of \_ ath Check onl one Be examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 the rising Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 🕶 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending after death.

Director: All investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D09834 6/21/07 Cale 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

[SALFY ROSEM FAUM 3 7 20 FAR FARRAGUT AVE KENSINGTOIN, MI) ZOSOS 720 KOSEM BADM 31. Date filed (Month, Day, Year, 32. Registrar's Signatu

DHMH 17 Rev 1/2001

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760,

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Records,

Division of Vital

DIVISION OF VICAL DECORDS, P.O. BOX 00/00,	þ	Dailinore, Maryland 21215-0030
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death		permit. Pages 1 and 2 should be filed within 72 hours after de
To the Funeral Director: After this certificate has been signed by the attending physician and	/sid led	Important: If item 27 is marked other than "natural", or items
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ciar lica ine	any injury or other traumatic event, the Medical Examiner n

		State of Maryland / Depa		Mental Hygie	ene								
		1. Decedent's Name (First, Middle, Last)	ificate of Death	Reg	g. No. 3. Time of Death								
Physicia	an			Month	Day Year								
/Medic		Cennea C. Wilson  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June	16 2007 11:28p M								
Examin	er	Holy Cross Hospital	Silver Spring		Montgomery								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, )	Birthplace (State or Foreign								
Director		577-30-3898 1□M 2⊠F 84 Yrs.	Willia Days Flouis Will.	June 6,									
*		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits								
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. 28a- notif	Director	D.C. Washingt	10f. Zip Code	100	g. Citizen of What Country?								
3a o		1110 Queen Street, N.E.	20002		U.S.								
ams 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Warned Forces?	las Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.								
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othe vent,	BeC	17. Father's Name (First, Middle, Last)	1	e (First, Middle, Ma	aiden Surname)								
Menta irked itic e	To E	Edward Washington	Anna Cu	nningham									
is ma		19220	Address (Street and Number or Rui Staleybridge Roa	ral Route Number, (	City or Town, State, Zip Code)								
it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Geraldine Taylor/Daughter Germa	ntown, MD 208/6		On Leasting Other Target Other								
if ite		20a. Method of Disposition   20b. Place of Disposition   1			0c. Location - City or Town, State								
irtmer irtant njury	-		oln Cemetery 6/28 Name and Address of Facility Fo		rentwood, MD								
Department of Important: If any injury or once.			01 Bladensburg Rd										
		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac	or respiratory arres	Interval Between								
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ite ha	Completed	( ) J		autopsy performe	prior to completion of cause of death?  □ No 1 □ Yes 2 □ No								
ertifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)									
his ce	일	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	ome 5 ☐ Residen	nce 6 □Other (Specify)								
After	on:	27. Manner of Death 1 ☑ Natural 5 □ Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred								
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within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier (Chack only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.											
Tot	Ž	29b. Signature and title of certifier  Multiple of Certifier  M. J.	29c. License number  D 0 0 5 7 ( 3		d. Date signed (Month, Day, Year) 06-18-2007								
(10)		30. Name and address of person who completed cause of death (Item 23a) (Type, P		na MD 20	1902								
Sta	te	Anuradha Arun, MD 1031 Georgia Av 31. Date filed (Month, Day, Year) 32. Registrar's Signature		11g, FID 20	,,,,,,,								
Registr		31. Date filed (Month, Day, Year)  JUN 2 6 2007  32. Registrar's Signature  A. Spiele											
17 Rev 1/20	001												

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 16, 2007 **Physician** 10:45a. June Sr. Ε. Wheaton. John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Silgo Creek Nursing Home 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 224 34 5498 1**⋒**M 2□F Yrs. Jan. 10, 1924 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 28a-f show other then "naturel", or items 23a or 28a-f showers, the Madical Examiner must be notified at N. Brentwood PG 1 No 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20722 Road Wallace 3909 Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Po Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Govt. Elementary/Secondary (0-12) Coflege (1-4or 5+) Forensic Tech. 12+ permit. Pages 1 and 2 should be filed.
Department of Heelith and Mental Hygi
Important: if item 27 is marked other:
eny injury or other traumatic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sallie Wheaton Thornhill Benjamin D. Wheaton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3909 Wallace Road, N Brentwood, MD, 20722 John E. Wheaton\_Jr/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State June 28,2007 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) veterans natur of Funeral Service Lightsee 22. Name and Address of Facility John T. Rhines Funeral Home 3015 12th NE Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Aspiration neumons Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 44 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No his 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1/S Natural 5 Pending n 24 hours after death.
The Funerel Director: Aft 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

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| Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 45666 Bacie MD 20711 of person who completed cause of death (Item 23a) (Type, Print) 1430C, CALCANT ex LN; 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary Ann Dorsey Young June 18, 2007 7:30 p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Nursing Center
5. Social Security Number 6. Sex 7.7 St. Mary's Leonardtown . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Director 64 02/19/1943 Maryland 220-40-5132 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hygiene. and the flam 27 is marked other than "natural", or items 23a or 28a-f show and: If Item 27 is marked other than "natural", or items 23a or 28a-f show and: If he Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No **Funeral Director** Maryland St. Mary's Abel1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20606 20915 Abell Road United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Black Completed by 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Dorsey ပ Leon Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20563 Tree Top Road, Lexington Park, Maryland 20653 Mary E. Young/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If I
any injury or
once, 4 ☐ Donation 5 ☐ Other (Specify) 06/25/2007 Leonardtown, Maryland Charles Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Records, P.O. Box 68760. physician Physician/Medical IF FEMALE for use . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an page 2 s autopsy perform 1∐ Yes 2√Z No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death I Director; 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral Completely filled i 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

M.D., 25365 Point Lookout Road, Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year)

32. Registrar's Signature
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Boyd, II,

4285

			For State of Ma State Registrar		artment of Health rtificate of Deatl		I Hygie Reg.	7001	22185
	Physicia	an	1. Decedent's Name (First, Middle, Last)				e of Death	Day Year	3. Time of Death
	/Medic	al .	Frederick L. Amberman  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	Jul n of Death	y 8,	2007 4c. County of Dea	6:20 P M
•	Examin	er	Frederick Villa Nursing	g Home	Catonsvil			Balti	
	Funeral Director		705-09-2014 <sup>№ 2□F</sup> g	(In yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date Min. (Mo. Feb.	of Birth nth, Day, Ye		thplace (State or Foreign ountry) ryland
	fand ow ut		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		_		10d. Inside City Limits
	a-f sh	ctor	Maryland Howard	Elkridge					1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What C	ountry?
	eath w	Funeral	6054 Hunt Club Road  11. Marital Status 12. Was Decedent E	ver in U.S. 13.	21075 Was Decedent of Hispanic C	Origin? (Specify Ye	s or No-	USA 14. Race - Am	erican Indian,
2-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 2 and 12 a	þ	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No 1 Yes 3 Widowed 4 Divorced Year or Dates:	)	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2X No Specif		etc.)	Black, Whi	white
<u>ဂ</u>	n 72 ho "natur edical l	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during me DO NOT use retired)	ost of working	161	b. Kind of Business	/Industry
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ם ם	be filed tal Hyg d other	Be C	17. Father's Name (First, Middle, Last)			ther's Name (First,		iden Surname)	
yla	should brund mand mand mand manded	ဥ	Adelbert P. Amberman	405 14-15	ng Address (Street and Num	linna Hans		Dite on Town Chair	Zin Ondol
<u>a</u>	nd 2 sh ilth and 27 is n r traun		19a. Informant's Name/Relationship (Type. Print) Ella J. Amberman / Wife	l l	Hunt Club Ro				
e,	ss 1 ar of Hea item :		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Date	200	c. Location - City o	r Town, State
Ē	Page ment c ant: If		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Meadowria	dge Mem. Pk.	7/12/200			Maryland
Dall	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai		21. Sinatur of Funeral Service Licensee	4	2. Name and Address of Fac 4107 WIlkens	Avenue, E	Baltim	ore, Mar	•
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5	Physician: r this certific ral director,	P.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien  27. Manner of Death 28a. Date of Injury	t 2 ER/Outpatier		Nursing Home 5		ce 6 □Other (Sp injury occurred	ecify)
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	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to the property of the funeral director, page 2 to the funeral director, page 2 to the funeral director.	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner stat	examination and/or in					
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License numbe		29d	. Date signed (Mor	nth, Day, Year)
	11		· Raymon Miller m		Da768	3		7/10/27	
1	01/		30. Name and address of person who completed cause of de-			MA	79.14	7/	
Ė	Sta	te	Raymond Miller 25 Man 5 dreu 3c Date filed (Month, Day, Year) 32. Egistrat JUL 1 1 2007	r's Signature	1 Mary 1	حقیاء ا	211	36	
	Registr	_	JUL 1 1 2007	~ D. B	route				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Adele V. Bowers July 5, 11:45 a M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 6446 Elibank Drive Elkridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 215-22-3761 Director 81 06/09/1926 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "naturel", or iteme 23a or 28a-f show event, the Medical Examiner must be notified at MD Elkridge 1 ☐ Yes 2 X No Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21075 6446 Elibank Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: Specify: White þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) John McShane, INC. Book Keeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental F int: If item 27 is marked of Stanley Wisniewski Jessie Wisniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Lash / Daughter 6446 Elibank Drive, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 07/09/07 Holy Rosary Cem. Baltimore, MD Cary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee any in M01378 23) Part? Enter the discusse of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ellock, or heart fail, re. Lift only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final YEARS METASTATIC LUNG CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Day signed by the af d be detached for 4 Pregnant at time of death 5 Other (specify) 0.0 9 Unknown 9 ☐ Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No of Vital To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA this Director: After this t in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification Division 1 Natural 5 Pending investigation within 24 hours efter death. To the Funerel Director: A 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ertified MEDICAL SOCTOR 1064931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIS COSCROVE, THE JOHNS HOPKINS HOSPITAL, GOT NORTH WOLFE STREET, BALTIMORE, MS 21287 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2007 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

			1 For State Registrar	State of Ma	arylan				ealth a D <i>eath</i>		ental Hy	gien Reg. N	Sim No.	7	221	87
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	deat	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S	S. 13.	Was Dece	dent of His	spanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race		can Indian,	
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	Hospi 24 hou Funer stely fill	edicai C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best on the basis of and manner star	examination	rledge, death on and/or inv	occurred estigation	at the time , in my opi	e, date and inion, deat	d place, ar h occurred	nd due to the	cause(s	s) and man nd place, ar	ner as st	ated. the cause(s	:)
	within Youth	Me	29b. Signature and title of certifier				290	. License	number			29d. Da	ate signed	(Month.	Day, Year)	
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Ì	0		30. Name and address of person who	completed cause of de	ath (Item :	23a) (Type, I	Print)	100	3 0		/	- (				
l			Wilbur Kus	295 Sto	ner	Ave	5+	307	W.	esta	ninste	/	NO	211	157	
	Sta Registra		31. Date filed (Month, Day, Year)	007 32. Registra	r's Signatu	ire	Red S								-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 8 per fh, 8778; Od 108/08/08/16 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:30PM 4,2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ILHCRES BALTIMORE HOSPICE 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 150M 2□F 219-62-0250 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Kes 2 No r 28a-f sh notified BALTIMORE **Funeral Directo** MD10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23a or? LOMBARD STREET 21224 STATES INITES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: ural", or items 2 I Examiner mu: Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 25 No Baltimore, Maryland 21215-0036 BLACK Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Item 27 Is marked other than "natu other traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Seçondary (0-12) College (1-4or 5+) ABORER INDUSTRIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ᇋ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 Nurial 2 □ Cremation 3 □ Removal from State CEMETERY JULY 10, 2007 BALTIMORE, MD 4 Donation 5 ☐ Other (Specify) MILLER'S METROPOLITAN 21. Signature of Funeral Service Licensee 39 N. BROADWA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Anal concer ears **Physician** metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exam sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 1 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident after death

Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 025205 cause of death (Item 22a) (Type, Print) 1 N. Churles St. ma

State Registrar 32 Registrar's Signature

			For State Registrar	State of Ma	ryland /		tment of H		nd Mental Hy	/giene Reg. No.	11111	22109
	4 1/2	*	1. Decedent's Name (First, Middle,	Last)					2. Date of D			3. Time of Death
Ψ,	Physic /Medi		Laurine	Cecelia	Bea	ard			Month	Pay	2007	11:00 A.M.
	Exami		4a. Facility Name (If not institution, g				b. City, Town, o		Death	1	County of Death	
		à.	Baltimore Washir					Burnie			nne Aru	
10	Funeral		,	.Sex 7.Age 1  M 2  F	e (In yrs. last i 95		If Under 1 Year Months Days		Min. 8. Date of B (Month, D	irth <i>ay Year)</i>	9. Birti Coi	nplace (State or Foreign intry)
200	Director		219-22-3437 Usual Residence of Decedent		90				reb.	10	1914	LID
	vland ow at		10a. State 10b. County		10c. City, To	own or Loca						10d. Inside City Limits
	Man a-f sh ified	tor	Maryland Anne A	\rundel			Ра	sadena				1 ☐ Yes 2 ☑ No
	or 28; e not	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Co	untry?
$\dot{\bigcirc}$	death with the Maryland rms 23a or 28a-f show r must be notified at	ral	770 221st Stree	et .				21122			USA	
\$	er dez tems ter m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Wa	is Decedent of I 'es, specify Cub	Hispanic Origii an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	0-	<ol> <li>Race - Amer</li> <li>Black, White</li> </ol>	
33	s after ; or ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	1 [	Yes 2₩ No	Specify:			Specify: Wh	ite
m \$	hours tural",	ed	15. Decedent's	Education	16	l 6a. Decedei	nt's Usual Occu	pation		16b. Ki	ind of Business/l	ndustry
8 E	ıin 72 t. ın "nat Medic	plet	(Specify only highest	grade completed) College (1-4or 5-	+/	(Give kii life. DC	nd of work done NOT use retire	during most o	of working			
212	d within giene.	Completed	Elementary/Secondary (0-12)	Jones de la companya	.,		Homema	ker			Househo	ld
5 7	al Hy d othe	Be	17. Father's Name (First, Middle, La						s Name (First, Middl			
五章	should the marker is marker umartic e	2	Roy Thomas	Tabler				Lill			merkle	
/ar	12 sh hand rism raum		19a. Informant's Name/Relationship		.				or Rural Route Num		or Town, State, Z	îp Code)
A	1 and Health em 27 ther tr		Lillian H. Geyer	^ (daughter	20b. Place	of Disposit	ion (Name of	i	a, MD 211		ocation - City or	Town, State
Auk) N imore, Mar	ages int of t: # ite		1 ☐ Burial 2 ☐ Cremation 3		ceme	etery, crema	tory or other pla natory I		uly 10			Maryland
L升ル外NE Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show important: if Item 27 is marked other than "natural", or items 23a or 28a-f show important: if Item 27 is marked other than 27 is marked other than 27 is marked at one of the 28 is a profiled at one.		4 □ Donation 5 □ Other (Special Service (in Service (	- / \	1,100.0		Name and Addr		2007 Stallin	1		
Pag Pag	permit. Departr Importa any Inje	4	1 Hm 2.	X7	).	3	111 Mou	ıntain	Road, Pas			ome, P.A. 122
100			23a. Pa./1. Enter the sease, or conshock, or heart failing. List of	omplic thens that caused	the death. D						,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Onek	11/4	200		acci	dent			Onset and Death
	/Medical		resulting in death)	a.  Due to (or as a	a consequen	ce of):	~		dent	1		
	Examiner		Sequentially list conditions,	b. breas-	+ 0	ome	er 1	with	neto	722	<u>3</u> 4	
(	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as	consequen	ce of):						
٧	executed n and ial-transit	хап	that initiated events resulting in death) Last	c Due to (or as a	a consequen	ce of):						
8760	be icia bur											
89	ificate g phys	Physician/Medical		u.						-		
Вох	death certifica attending ph I for use as th	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	pf pregnancy	ath 3∏E	ctopic pregnanc	OV.			23d. Date of del	
	deat he atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at			Other (specify)	-y			Month	Day Year
P.0	at the	Phys	9 ☐ Unknown  Part II. Other significant condition			- 1- 41		one in Daniel	One Die	Itohoooo	una cantributa ta	the cause of death?
	w requires that the death been signed by the atter should be detached for u	by	Part II. Other significant condition	s contributing to death bu	it not resultin	g in the una	enying cause gi	ven in Part I.		Yes 2		obably 4 Unknown
Ö		Completed								/		
360	2 2	hdm							— 24a. Wa	is an opsy formed?	prior to death?	topsy findings available completion of cause of
<u></u>	n: Th ficate r, pag		25. Was case referred to medical					00 81	1 Yes	2 <b>X</b> No	1 ☐ Yes	2 No
Ξ	Physician: this certificantal director,	o Be	examiner?	Hospital: 1 Minpatie	nt 2□FR/	Outpatient	3□ DOA Ot	her	of Death <i>(Check only</i> sing Home 5 ☐ Re		6 □Othor /Sac	nife!
ō	g Phy er this eral d	n: To	27. Manner of Delath	28a. Date of Injur (Month, Day	ry 28	b. Time of	28c. Inju		28d. Describ			ony)
Ö	Attending r death. ector: After y the fune	atio	1 Natural 5 ☐ Pending 2 Accident investiga	tion	( rear)	Injury		Yes 2 N	0			
Division or Vital Records,	r Atte er de irecto	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home c. (Specify)	, farm, stree	t, factory, office			(Street ar		ıral Route Number,
Q	ital or irs afte iral Dir iled in											
	Hospital 24 hours a Funeral rely filled	edical		Physician: To the best of xaminer: On the basis of and manner sta	examination							
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	and manner Sta			29c. Licen	se number		29d. Da	ite signed (Mont	h, Day, Year)
	⊢≯⊢ŏ		ACA	n.	M		D4	3977	7	Fin	m a	2007
	4		30. Name and address of person w	ho completed cause of de		a) (Type, Pr	int) N		<u>^1</u>		, 1	2:=1:
	,/		Compres ones	mg. 30	1 42	30017	Y W	wey	Wen B	mn	اسه	21061
	Si Regis	tate trar	31. Date filed (Month, Day, Year)  JUL 1	2007 32. Registra	ar's Signature	N AND	ede					

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Ulrector.

cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Lung Cancer  Due to (or as a consequence of):				4 years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of del Month	ivery Day Year
	ons contributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did toba 1  Yes 24a. Was an autopsy performe 1 Yes 28	2 No 3 Pr	othe cause of death?  robably 4 Unknown  utops findings available completion of cause of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Propatient 2 ☐ ER/Outpatient 3	26. Place of Death  Other: 4 Nursing Hon		ce 6 □Other (Spe	cify)
27. Manne of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at 2 Work?	8d. Describe how		
3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		actory, office 2	8f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	g Physician: To the best of my knowledge, death occ Examiner: On the basis of examination and/or investi- and manner stated.				
29b. Signature and title of certifier	•	29c. License number	290	d. Date signed (Mont	h, Day, Year)
I down au		85.5-000		71 ~	5001.

22101

3. Time of Death

Birthplace (State or Foreign Country)

NY

WHITE

HEIDEN

24 hours

days

10d. Inside City Limits

1 XYes 2 No

N/A

al: 35 M

State Registrar

			For State of Ma	ırylan		artment of ertificate or			giene Reg. No.	7 22191
100	Physici	an	1. Decedent's Name (First, Middle, Last)	P +	=11	TZ-		2. Date of Dea		3. Time of Death
Y	/Medic Examin		4a. Facility Name (If not institution, give street and number)	J 6	0.	4b City, Town,	or Location of Dea	th 1	49 County of De	eath 13 1 15
	Funeral			e (In yrs.	last birthday	) If Under 1 Year Months Days		8. Date of Birt	v. reari	Irthplace (State or Foreign Country)
ill parties	Director		218-18-5234 NXM 2□F Usual Residence of Decedent	82	Yrs.	Months Bay	3 Tiodis Willi	Feb 1	7,1925 Ma	aryland
	Maryland f show led at	ō	10a. State 10b. County n/a		y, Town or L Balti		-			10d. Inside City Limits 1    Yes 2   No
	or 28a- oe notifi	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	•
	death w	Funeral	2418 Foster Avenue  11. Marital Status  12. Was Decedent E Armed Forces?	Ever in U.	.S. 13		1224 Hispanic Origin? (I Iban, Mexican, Pue	Specify Yes or No	U.S. A	merican Indian,
36	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ ☐ Yes 2 ☑ If Yes, Give Year or Dates:	10		1 ☐ Yes 2 ☐ XV		nto nican, etc.)	Black, W Specify:	White
215-0036	n 72 hou "natura edicai E	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Dec	edent's Usual Occ e kind of work don DO NOT use reti	upation e during most of wo	orking	16b. Kind of Busines	
7	ed withii ygiene. ier than t, the M	Comp	Elementary/Secondary (0-12) College (1-4or 5 7 th	+)		perint	endent			Baltimore
land	uld be fill fental H rked oth iic even	То Ве	17. Father's Name ( <i>First, Middle, Last</i> )  Frank Bentz					<sub>ime (First, Middle,</sub> aret Ko	Maiden Surname) ehler	
Maryland	d 2 th a tra		19a. Informant's Name/Relationship (Type. Print)  Joyce Fair (Daughter)						er, City or Town, State	
ore,	90-		20a. Method of Disposition  1★ Burial 2 □ Cremation 3 □ Removal from State	C	cemetery, cre	osition (Name of ematory or other p		Date	20c. Location - City	
altimore,	permit. Pag Department Important: i any injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Sac					altimore, i Funeral	
ä	Der any		Polit Jodans	the deat						Md. 21222 Approximate
	Physician		23a. Part1. Enter the dised se, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (final disease or condition	ne.	$\leq M \lambda$		l Cal VC	ika wa kata wa kata wa kata wa kata wa kata wa kata wa kata wa kata wa kata wa kata wa kata wa kata wa kata wa	of 1HE	Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a	a consequ	uence of):			101	09	
<b>,</b>	pe:	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequ	uence of):					
o O	ficate be executed physician and is the burlal-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a	a conseq	uence of):					
68760,	ificate b g physic as the bu	edical	d							
. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  to the Funeral Uirector. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 4 □ Pregnant at	2 🗆 Feta	al death 3	□Ectopic pregnar			23d. Date of o	delivery Day Year
P.O.	res that the de signed by the a be detached f	hysic	9 ☐ Unknown							
rds,	quires the signed and the de	by	Part II. Other significant conditions contributing to death but	ut not resu	ulting in the	underlying cause (	given in Part I.	23e. Did to	,	to the cause of death?  Probably 4 □Unknown
Records,	e law require has been sig e 2 should b	Completed						24a. Was	osy prior t	autopsy findings available completion of cause of
Vital F	sician: The law certificate has b irector, page 2 s	Be Cor	25. Was case referred to medical				26. Place of De	1  Yes	rmed? death 2☐/No 1☐Y	
or <	Physic er this ce eral direc	မ	examiner?  1 Yes 2 No  Hospital: 1 Inpatie  27. Manner of Death  28a. Date of Injur	ry	ER/Outpatie	ent 3 DOA			dence 6 Other (S	pecify)
Division or	terding Ph earh. tor: After thi the funeral	cation	1 Natural 5 Pending (Month, Day 2 Accident investigation 3 Suicide 6 Could not be 288 Place of inju		Injury	M N	☐ Yes 2 ☐ No			
	tal or At s after d al Direc ed n by	Certification:	4 Homicide determined 28e. Place of inju-	ry - At ho c. (Specify	ome, farm, s fy)	treet, factory, offic	e	28f. Location (S City or Tov	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	f examina	owledge, dea ation and/or i	th occurred at the nvestigation, in m	time, date and plac y opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
	To the within complete	Me	29b. Signature and title of certifier			1 .	nse number	I	29d. Date signed (Mo	onth, Day, Year)
•	4		30. Navie and address of person who completed cause of do	eath (Item	n 23a) (Type	, Print)	1236 1 PC1	0	JULY 10	2007
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registra	11/2 ar's Signa	301 S	TPACK	I PC 1	BALTI	MONE 1	110 21205
	Registr		JUL 1 1 2007	A. Frank	B. 1	bases				

DHMH 17 Rev 1/2001

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

29b. Signature and title of certifier

Jason Black

31. Date filed (Month, Day, Year)

Reg. No. 2. Date of Death 3 Time of Death Month 2:25 P.<sup>M</sup> July 2007 4c. County of Death Baltimore 8. Date of Birth 9. Birthplace (State or Foreign Jan. 26, 1952 Maryland 10d. Inside City Limits 1 ☐ Yes 2√ No 10g. Citizen of What Country? U.S.A. 14. Bace - American Indian. Black, White, etc. White Specify. 16b. Kind of Business/Industry American Can Com. 18. Mother's Name (First, Middle, Maiden Surname) (unk) 20c. Location - City or Town, State |Baltimore, Maryland 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A. Approximate Interval Between Onset and Death MONTHS 23d. Date of delivery Year Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy performed? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Haspice 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) July, 8,2007 Suite 209, TOUSON MO 21204

State Registrar

24 hours a

ST.

29c. License number 20061199

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

6565 Norm Charles

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 0632 M **Physician** NANCIS ORNELIUS 0 03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. **№** M 2□ F Months Hours 89 04/28/1918 NY Director 549-34-3445 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Show be notified at 1 ☐ Yes 2 No Director MD Gambril1s Anne Arundel 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 21054-USA 'natural", or items 23a 2604 Chapel Lake Dr. #110 must by Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1/2 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. the Medical Examiner 1 and 2 should be filed within 72 hours after of Health and Mental Hyglene. em 27 Is marked other than "natural", or iter 1 Never Married Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Air Force Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nelson Ruth James Brady traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any Injury or other trau Patricia Brady/Wife 2604 Chapel Lake Dr. #110 Gambrills, MD 21054-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages Jul 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Bethesda, MD 4 Donation 5 ☐ Other (Specify) USUHS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 01 **Physician** /Medical Due to (or as a conseque ce of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): P.O. Box 68760, physician SBS IF FEMALE use a If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day for Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 2 No 1∐ Yes Hospital or Attending Physician; funeral director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Yes 1 Dinpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation Injury s after dec.
ral Director: Aftr 1 ☐ Yes 2 ☐ No 2 ☐ Accident Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

141

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

ne and address of persor

Year)

DHMH 17 Rev 1/2001

od cause of death (Item 23a) (Type, Prin

32. Registrar's Signature

29c, License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#1 per PHYS . G869#20b per fb . 7/11 07 ws

State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Willie 3. Time of Death Robert Cole Month **Physician** 0920AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Plus Elder Sparrows Point Baltin Hopkins Facility rore. 5. Social Security Number 6. Sex 7. Age (In ) ast birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 10 M 2□ F 244 28 0611 79 Yrs. Director 07/10/1927 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or Items 23s or 28e-f show treumatic event, the Medical Examinar must be notified an MD N/A Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5350 Penning USA 21239 tarkway Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature!" ...". once injury or other treumatic even. 12. Was Decedent Eyer in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑No Specify: 3 Widowed 4 □ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cook Food 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Columbus Mecre Cole Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Saunders/Nièce 5350 Pening Parkway Balto, MD 21239 Margaret 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 07 i 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Green mount Crematory Bultmore, MD 07/06/07 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address Facility augus C. Greene Fureral SrVCS M01363 4905 York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician Dementia 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Nb. executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ br. laten 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 X No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSTU 1 ☐ Yes 2 No 2 this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Willel 2057 045757 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Ave. Batt mo Matthew Michabney 21224 . Registrar's Signature 31. Date filed (Month, Day, Year) State 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death James Colbert **Physician** 06 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death **Examiner** atous ville recan St. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1**7** M 2□F 220-20-4847 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No **Funeral Director** timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21228 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 239 any injury or other traumatic event, the Man ecar Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Be ည 19a. Informant's Name/Relationship (Type. 21228 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 21. Signature of Fureral Service Licensee Bathmore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn certificate 1∐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2√ No Be 26. Place of Death (Check only one) 20 No Hospital: Other: 4 \sum Nursing Home 5 Residence 6 \subseteq Other (Specify) P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: neral Director; After filled in by the funera 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

Registrar DHMH 17 Rev 1/2001

State

Charles M. Harrison MD 3900 Loch Raven Blvd. Baltimore, MC

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 9910: 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician 6,2007 21271 aurice /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Buttmore Cit If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min. Hos Pital HOPKINS JOHNS Date of Birth (Month, Day Ye 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 1XYes 2 No be notified Director all timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must the medical examiner must the medical examiner must the medical examiner must the medical examiner must the medical examiner must the medical examiner must be a second examiner of the medical Was Decedent Ever in U.S. Armed Forces? anstan 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No <u>م</u> 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) aftsman Uphalstery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Wilkerson tari N. Chase 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health as
Important: If item 27 is any injury or any 9969 Tuscarora nd handallstan mp 21133 Zenia M. Chose / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Valletin C. Greene Juneau Service Greenment 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. handalistan mo 21133 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner propary burial-trar Due to (or as a consequence of) ed by the attending physician detached for use as the burial Box 68760 be Physician/Medical the as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 2 No 1 Nes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate or completely filled in by the funeral director, pag Yes 2□No 25. Was case referred to medical Be 26. Place of Death (Check examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 XNatural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of ceriffier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 57 600 N Walfe Jonathan

DHMH 17 Rev 1/2001

State Registrar (Month, Day, Year) UL 11 2007 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 31 per DVR C869 7/11/07 Western State of Maryland Department of Health and Mental Hygiene

Certificate of Death

			1 - State Registrar			Certificat	e of E	eath		Re	g. No/)	117	00107			
Ü	Discontinu	G	1. Decedent's Name (First, Middle, Las	t)					. Date of Death Month	nth Day Year						
	Physicia /Medic			Antho	ny Co	megys						007	9.03 PM			
	Examin		4a. Facility Name (If not institution, give			-	Town, or				4c. Coun	ty of Death				
			Levindale He	ebrew Genatric C	enter & H	ospital $\mathcal{B}^{f}$	HLT1	MUR	E		<u> </u>		N/A			
1	Funeral		5. Social Security Number [ 6. 50	ex 7. Age (li □ M <sub>X</sub> 2 □ F	Tyrs. Idsi Dirti	Months	1 7001	If Under 2 Hours	Min. 8	Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign intry)			
L.	Director		214-90-4974	- "X	42	rs.				Jul 2	5, 1964	L	Maryland			
	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location							10d. Inside City Limits			
	farylarylarylarylarylarylarylarylarylaryl	ō	Marvland	N/A			1	3altimo	ro				1 <b>X</b> Y <b>x</b> s 2 □ No			
	the N	ect	10e, Street and Number	19//		10f. Zip		Jaidino	10	10	Og. Citizen o	f What Cou	intry?			
	a or	듑	707 Bartlett Avenue					24	218				S.A.			
	eath ns 23 musi	era	11. Marital Status	12. Was Decedent Eve	r in U.S.	13. Was Dece	dent of His			fy Yes or No-		ace - Amer	ican Indian,			
36	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	1 Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No. If Yes, Give		If Yes, spe 1 ☐ Yes		n, Mexican Specify:	, Puerto Ri	can, etc.)	Spec	ack, White	, etc. Black			
Maryland 21215-0036	2 hour atural' cal Ex	ted b	15. Decedent's Ed	Year or Dates:	16a. I	Decedent's Usu	al Occupa	tion	a a warking		16b. Kind of	Business/li				
715	hin 7; In "n Medi	Completed	(Specify only highest gra	College (1-4or 5+)		(Give kind of wo life. DO NOT u	ork aone a ise retired)	uring mosi	or working			Distraction	Camponico			
7	d with giene ir the	ĕ	12					abore	r			Private	Companies			
Þ	othe	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (i	First, Middle, N	flaiden Surna	ame)				
<u>a</u>	should be filed within and Mental Hygiene. s marked other than umatic event, the Me	ToE	George	D. Comegys						Sara	ah L. Co	megys				
ary	d 2 should be f th and Mental H 7 is marked ol traumatic eve	-	19a. Informant's Name/Relationship (	Type. Print)	19b.	Mailing Addres	s (Street a	nd Numbe	or or Rural I	Route Number,	City or Tow	n, State, Z	ip Code)			
Σ	and 2 alth a 27 is		Sarah Comegys			707 Ba	artlett A	venue i	Baltimo	re, Marylar	nd 21218	3				
<u>re</u>	of He		20a. Method of Disposition	I	20b. Place of cemeter	Disposition (Na y, crematory or	me of other place	e)	Dat	te :	20c. Location	n - City or T	Town, State			
Ĕ	Page hent o		1 ☑ B rial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specifi			Loudon P	ark Cer	neterv		07/12/07		Baltim	ore, Md.			
Baltimore,	permit. Departir Importa any Inju		21. Signeture of Funeral Service Leter	se C	22. Name and Address of Facility											
m	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		I serve C	2510	11 DE	-	Estep	Brothe	rs Fune	ral Service altimore, M	P. A.	,				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do n	ot enter the mo	de of dying	, such as	cardiac or	respiratory arre	est,		Approximate Interval Between			
	Physician <sup>1</sup>		Immediate Cause (Final	Onset and Death												
	/Medical		resulting in death)	ease or condition												
	Examiner			SEPS	15											
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (crase o	as a nonsequence of):											
8	icate be executed physician and s the burial-transit	Examiner	that initiated events	C												
ó	execan an an rial-tr		resulting in death) Last	Due to (or as a c	or as a consequence of):											
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98	tifica ig ph as th	Medical		-11		V <del>III</del>						1	-			
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 ☐ Live birth 2 [	pregnancy	3 □Ectopic p	regnancy					Date of deli				
-	death ie atte ad for	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tirr 9□Unknown	ne of death	5 ☐ Other (s						Month	Day Year			
P.O.	at the by th tache	h.	9 ☐ Unknown							11						
S,	gned gned		Part II. Other significant conditions of	=	ot resulting in	the underlying	cause give	n in Part I.					the cause of death?			
5	en sig	ed	PANCREATI	113						1 □ Ye	es 2124 No	3 ∐ Pro	obably 4 Unknown			
ပ္ထ	aw re is be 2 sho	Completed by								24a. Was a		b. Were au	topsy findings available completion of cause of			
Ä	The I	E								perforr	ned? 2 <b>X</b> No	death? 1 ☐ Yes	·			
ta	an: rtiffica tor, p	Be	25. Was case referred to medical					26. Place	of Death (	Check only on						
>	Physician: r this certifica ral director, p	.0	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 12 Inpatient	2 ER/Out	patient 3 D	OA Othe	er: 4 □ Nu	rsing Hom	e 5 ☐ Reside	ence 6 🗆 0	Other (Spec	cify)			
0	g Ph ter th	ä	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. T	ime of njury	28c. Injury Work	at	28	d. Describe ho	w injury occ	urred				
<u>Ö</u>	ath. r: Af	atio	1 Natural 5 Pending 2 Accident investigation	1		M		∕es 2□	No							
Division or Vital Records,	Atte	ifi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc. (	- At home, fai	m, street, facto	ry, office		28	If. Location (St City or Town	reet and Nu	mber or Ru	ıral Route Number,			
Ö	tal or s affe at Dir	Certification: To			£ =97					, , , , ,						
	To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical (	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	nysician: To the best of r miner: On the basis of ex and manner state	camination and	, death occurre d/or investigation	d at the tin on, in my o	ne, date ar pinion, dea	nd place, ar ath occurre	nd due to the c d at the time, d	ause(s) and late and plac	manner as e, and due	stated. to the cause(s)			
	o the ithin o the omple	Me	29b. Signature and title of certifier			29	9c. License	number		2	9d. Date sig	ned (Monti	h, Day, Year)			
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•			30. Name and address of person who		th /Itom 22a) /		-41/1/		•		110	11				
	6		GIZAW WOLDER			FST 8	ELVI	DEK	EE A	WE. E.	ALTIM	OKE.	ms 21219			
		ate.	31. Date filed (Month, Day, Year)	32. Registrar's			)		4	1 Di	101110	)				
	Sta Regist		and Inc la com		117	กกว 🎉		K	Rose	dis.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician**  $p^{\mathsf{M}}$ 07/06/2007 6:30 Isabelle Crenshaw /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/ABaltimore 2600 Roslyn Avenue If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 □ € Director 218-28-2875 Sep 12, 1911 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ns 23a or 28a-f shov must be notified at 1 **∏ Ye**s 2 **□** No Directo N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a v Examiner must b 2600 Roslyn Avenue 21216 USA Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) McDonogh School Domestic Engineer n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be sent of Health and Mental Bertha Pierson Earl Pierson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trat Phyllis Holsey Daughter 2600 Roslyn Avenue Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cyemation 3 ☐Removal from State 07/11/07 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 de of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that cause, the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Deseage Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signed | 2 should be det þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autonsy performed? or Attending Physician: The page 2 No 25. Was case referred to make all examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 3□ DOA 1 ☐ Yes 2 ☐ ER/Outpatient Certification: To 1 Inpatient 6 ☐Other (Specify) After this 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death

To the Funeral Director: filled in by Hospital completely

> State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

Day, Year)

DHMH 17 Rev 1/2001

and manner stated.

32 Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

# Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director

Physician
/Medical
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	_	State of N  State Registrar	/laryland		partment of F ertificate of		and Mer		2 3 20		2010)		
	ı	Registrar  1. Decedent's Name (First, Middle, Last)			Crimoate or	Doutin	2.	Reg.  Date of Death	No.	111	3. Time of Death		
sician			one	1251	ì			-10	Day 2.00	Year	11/2		
edical		4a. Facility Name (If not institution, give street and number			4b. City, Town, o	r Location o		aly &	4c. County	of Death	PAL		
mine		KONTHWEST HESPITAL	-	-	121 112	1/12-	TOWN		BA	itin	0.15		
ral		10012/11000	Age (In yrs. Ia	_	ay) If Under 1 Year	If Under		Date of Birth (Month, Day, Ye		9. Birtho	lace (State or Foreign		
or		212-40-3355	65	Yrs.	Months Days	Hours	Min.	2/29/194	11	Mary	land		
	- 1-	Usual Residence of Decedent											
		10a. State 10b. County		, Town or						] 1	0d. Inside City Limits		
Director	3	Maryland Baltimore	U	wings	s Mills						1 □ Yes 2M No		
1 2		10e. Street and Number			10f. Zip Code				Citizen of \		*		
1 2	8	3420 Associated Way Apt.	413		21117			J	United				
To Be Completed by Emeral Director		11. Marital Status 12. Was Deceder Armed Force	s?	3. 1	<ol><li>Was Decedent of H If Yes, specify Cub.</li></ol>	ispanic Ori an, Mexicar	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)		ce - Americ ck, White,			
تا		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give			1 ☐ Yes 2 反 No	Specify:			Specif		ite		
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Completed		15. Decedent's Education (Specify only highest grade completed)		(Gi	cedent's Usual Occup ive kind of work done e. DO NOT use retire	durina mos	t of working	100	. Kind of B	usiness/ind	dustry		
8	1	Elementary/Secondary (0-12) College (1-4c	or 5+)	me		-/		١,	Retai	l Cro	COLL		
		11 17. Father's Name ( <i>First, Middle, Last</i> )			Manager	18. Mothe	er's Name (Fi	rst, Middle, Maid			CELY		
8	5	Clarence E. Shaw					,	Louise 1		.,			
ř	-	19a. Informant's Name/Relationship (Type. Print)		10h Ma	ailing Address (Street						Cada		
			<b>5</b>	i	Kearney D				,	2111			
	1	Debbie L. Paris / Daughte: 20a. Method of Disposition			sposition (Name of crematory or other place		Date		Location -				
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te Lou	emetery, c don 1	rematory or other pla Park Cemet	ery 0	7/13/2			•	iaryland		
once.		21. Signature of Funeral Service Licensee			22. Name and Address Hubbard	ss of Facilit	al Hom	e. Inc.					
Ы		Marke T. Bo			4107 Wil				more,	MD	21229		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a												
an	ĵ	disease or condition	CA	2DI	Onyon.	4704					Onset and Death		
al		Due to (or as a consequence of):											
er .		Sequentially list conditions b.											
	<u> </u>	if any, leading to immediate cause. Enter Underlying											
lical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or a cause in the condition of the conditio											
	- 1	resulting in death) Last  Due to (or as a consequence of):											
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MA		IF FEMALE: 23c. If yes, outcor	ne of pregnar	nev									
Dhveician/Ma		in the past 12 months?	2 □ Fetal at time of de	death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	/				ite of delive onth	ery Day Year		
1.00		1 ☐ Yes 2 ☐ No 4 ☐ Fregnam 9 ☐ Unknown 9 ☐ Unknown		auı	5 Uther (specify) _				_				
占	=	Part II. Other significant conditions contributing to death	but not resu	Iting in the	e underlying cause giv	en in Part I		23e. Did tobac	co use conf	tribute to th	ne cause of death?		
2	2	CONGESTIVE HEART				ZONA		1 Tes	2 1No	3 ☐ Prob	ably 4 □Unknown		
Completed		Auto d'ann				P - 1		0.4- 11/	0.45	107			
_ E	-	Treaty Disease	67	223	746E	200	44	24a. Was an autopsy performed		prior to condeath?	psy findings available mpletion of cause of		
		DISEASE ! DIABE TO	s he	tille	tus			1□ Yes 2☐	No	1 ☐ Yes	2 NO		
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, <u>c</u>	5	1 ☑ Natural 5 ☐ Pending (Month,	Day Year)	Injur	ry Wo	yan k? Yes 2□		. Describe now i	njury occur	rea			
100	2	3 Suicide 6 Could not be 390 Place of	iniury - At hor	me farm.	street, factory, office	163 2		Location (Stree	t and Numl	her or Rura	al Route Number,		
Cortification:		4 Homicide determined building,	etc. (Specify	)	,,,		201.	City or Town, S	tate)	_ J, g, / Iu/c			
		29a. Certifier 1 Certifying Physician: To the be	st of my know	wledge, de	eath occurred at the ti	me. date ar	nd place, and	due to the caus	e(s) and m	anner as s	tated.		
Modical	3	(Check only one)  2 Medical Examiner: On the basis and manner	s of examinat										
M	2	29b. Signature and title of certifier			29c. Licens	e number		29d.	Date signe	ed (Month,	Day, Year)		
		) (Basil)	ne)		1	185E	25	<	Jula	8	2007		
	-	30. Name and address of person who completed cause of	f death (Item	23a) (Tur	ne. Print)	11	0001		·FA	/	0-1-		
		OR / ANDO B ON A	A / AL a	ere	7)	RAN	ONTHE DALLS	ton	nest	prote	1 2 112°		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death OMER Elizabeth 200 Jul 6 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 ☐ M 2 🕏 F 579-68-8699 74 Scotland 1932 Oct 16 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Howard Woodbine 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 15005 Scottswood Court Great Britain 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 √2 No Specify: Specify: white 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Connor Margaret (maiden name unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vicky Cutroneo (daughter) 15005 Scottswood Ct., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 7-10-07 Sykesville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel Dag Haight Herbert Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disease Due to (or as a consequence of): Ssendal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ Death 24a. Was an autopsy performed 1□ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Inpatient Other: 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury (Month, Day Year)

**Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed physician are the burial-t Division or Vital Records, P.O. Box 68760, the signed by t has e 2 page certificate within 24 hours after death

To the Funeral Director:

completely filled in by the f

Examiner Physician/Medical þ Completed Be ဥ Certification: Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

'natural', or

al Hygiene.

Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i once.

**Physician** /Medical Director

Funeral

þ

Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

State Registrar

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number ame

70641

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

impleted cause of death (Item 23a) (Type, Print)

BOOK REVEY WEEK ROAD Balhmore 201-109

6 ☐ Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9869 7-11-07 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JULY 8 2007 1:05 P M CANNON GLASS **EDYTHE** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE BALTIMORE 7440 PARK HEIGHTS AVENUE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🖫 F 12/23/1908 Director 218-<del>305</del>-5283 98 PA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ıral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No MD BALTIMORE BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7440 PARK HEIGHTS AVENUE 21208 U.S.A. Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. Specify: ģ 3 Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE NURSING ilth and Mental Hygier 27 Is marked other the r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NEWLAND **GLASS** ROSE HARRY ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau
once. 7440 PARK HEIGHTS AVENUE - BALTIMORE, MD 21208 JOANNA LEVY / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HEBREW FRIENDSHIP 07/10/2007 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the design of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1□ Yes 24 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No Medical Certification: To 1 Tyes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending Vithin 24 hours after co-1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only one) 29c, License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 11

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Carol Ann Channel 06:25p M 07 04 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford 9. Birthplace (State or Foreign Country) 602 Roxburch Terrace If Under 1 Year Per Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 M 2 X F Director 07/23/1952 UT 5-2-9 residence 3 5-7 edent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 □Yes 2 No Director MD Harford 10e. Street and Number Bel Air 10g, Citizen of What Country? 10f. Zip Code Funeral 602 Roxburch Terrace Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Wayne Coombs
19a. Informant's Name/Relationship (Type. Print) Lavern \_Stenguist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Stephen Channel/Husband 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place)

Air,

Date MD 21015 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Jul 6 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2007 21. Signature of Funeral-Service Licensee Stipley Johnson M00382 Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| All attentions are all times and the disease of the control of the cont Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Physician years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, sician Physician/Medical the ate has been signed by the attending phy page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 1 Yes 20 No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 22 No this certificate 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Yes 1 ☐ Inpatient Certification: To 28a. Date of Injury after death.

I Director: After this of in by the funeral di 27. Manner o Death

1 Natural
2 Accident 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital Notes that the cause (s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certified

8

DHMH 17 Rev 1/2001

State Registrar Georgia Ave NW Washington DC

MD

6900

32. Raistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David C. Van Edro

31. Date filed (Month, Day, Year)

			_ For	State of Marylar				Mental Hygie	ene				
			State     Registrar		Cei	rtificate of L	Death	Reg	No.	17	22203		
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day	Year	3. Time of Death		
'	/Medic		Elouise			Day		July		007	4:45a. M		
).	Examir	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or		h	4c. County				
			Lorien Nursing 5. Social Security Number 6. S		last hirthday)	Mt. If Under 1 Year		8. Date of Birth	Car	rol	pplace (State or Foreign		
	Funeral Director			□ M 2 🟋 91	Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear)	Cou	intry) SC		
			Usual Residence of Decedent					109 12	1.7				
	how at		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits		
	e Ma 3a-f s	cto	MD NA	E	Baltim	ore					1XIYes 2 No		
	or 24	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of V		·		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	7109 Campfield	Road  12. Was Decedent Ever in U	16 112		1207	Specify Vec or No		S Ameri	ican Indian,		
	item item iner n	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?  1  Yes 2 No	7.5.	Was Decedent of Hi If Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)		k, White			
36	urs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 🎇 No	Specify:		Specify	/: E	Black		
ŏ	2 hou		15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	ation	rking 16	Bb. Kind of Bu	usiness/Ir	ndustry		
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<u>Y</u> a	should be filed w tnd Mental Hygie s marked other ti umatic event, th	은	James White	T. D. (1)	405 14:15		Isadora Cloud and Number or Rural Route Number, City or Town, State, Zip Code)						
Baltimore, Maryland 21215-0036	o. 00 97 m		19a. Informant's Name/Relationship (								,		
ė,	1 and 2 Health tem 27 i		JoAnn Lipscomb- 20a. Method of Disposition	-Daughter 206.	17109 Place of Dispo	Campficosition (Name of	eld Ave	Baltin Date 20	ore, C. Location -	Md City or T	21207 Fown, State		
no	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		ty□ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Specii</i>	Removal from State		<sub>matory</sub> or other plac w <b>ri</b> dge	*/ 7/10		altimo				
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			3a. P. 11. Enter the disease, or com s, ock, or heart failure. List only	plications that caused the dea							Approximate Interval Between		
-	Physician		mmeriate Cause (Final lise se or condition	_a Myocardia						- 7	Onset and Death  2 wks		
JA.	/Medical		realiting in death)	Due to (or as a conse		araction	-				Z WICS		
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V _	and I-tran	Examiner	that initiated events resulting in death) Last	c. Hypertens Due to (or as a conse	uence of):						Yrs		
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687	ficate physis the	edical		d. Diabetes		CUD LL					110		
Box	leath certific attending p I for use as	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr					23d. Da	te of deliv	very		
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fet 4□Pregnant at time of		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			Mo	nth	Day Year		
P.0	t the by the	hys	9 🗆 Unknown	9□Unknown									
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Me	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.				the cause of death?		
ord	equir een si ould I	ted	Obesity					1 ☐ Yes	2 No	3 ☐ Pro	obabły 4 ∏Unknown		
ec	has be	Jple	Immobilty Synd	drome				24a. Was an autopsy	- 1	prior to c	topsy findings available completion of cause of		
<u>~</u>	The	ပ္ပ						perform 1☐ Yes 2	ed? <b>X</b> No	death? 1 □ Yes	2□ No		
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Division or Vital Records,	ding I. After funer	ioi	27. Manner of Death  1 Natural 5 ☐ Pending investigatio	(Month, Day Year)	Injury	Wor	yan k? Yes 2 ☐ No	200, Describe flow	rinjury occur	rea			
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	To the within To the comple	Ž	29b. Signature and title of certifier	0.11	, 44	29c. Licens	e number	290	d. Date signe	d (Month	h, Day, Year)		
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	1		30. Name and address of person who								507		
			Allen Reilly N 31. Date filed (Month, Day, Year)	1D, 801 T611		Ave Su:	te Dl	Frederic	k, Mo	21	701		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mary and 15 each rest of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** DVIS RN NK 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, City, Town, or Location of Death Examiner ethesda Montgomery HOSP LOURBA ital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 04/21/1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 218-56-54 **1**2√M 2□F South Wales Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show notified at 1 ☐ Yes 2 No Director MD Glen Echo Montgomery 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code a or 6107 Yale Ave. 20812-United States 'natural', or items 23a dical Examiner must t Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner Armed Forces:

1 Yes 2 No
If Yes, Give
Year or Dates: 1940 -46 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 2 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry International Money Pu Elementary/Secondary (0-12) College (1-4or 5+) Manager (Fund) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Davies Beatrice Smith ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Douglas J. Davies/Son 6107 Yale Ave. Glen Echo, MD 20812-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jul 7 Chesapeake Crematory Inc.2007 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rapp Funeral & Cremation Services M00382 lud Kolimaini Silver Spring, Maryland 20910-933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracranial Hemorrhage **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown After this certificate has been signed in funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 12 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: 24 hours after deat Funeral Director: filled in by within 24 hor To the Fune completely fi

State Registrar

Medical

29a. Certifier

(Check only one

29b. Signature and title of gertifier

31. Date filed (Month, Day,

Year) 1 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven D. Wilkes MD 9901 Medical Ctr Dr. Rockville MD 20850 32 Registrar's Signature

5. Wello

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D63195

29d. Date signed (Month, Day, Year) 07-02-2007

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** M 0623 Annie M. Evans Jul 9, 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner N/A **Baltimore** Union Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Min Months Days Hours 1□M 2□₹ Mar 30, 1919 Virginia Director 577-30-7951 88 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County r 28a-f show notified at 1 □YMes 2 □ No N/A **Baltimore** Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or dical Examiner must be 3207 Magnolia Avenue 21227 U.S.A. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ NX Baltimore, Maryland 21215-0036 Specify Specify **Black** þ 3 ☐ Wijdowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Private Home than Elementary/Secondary (0-12) Homemaker Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Johnson Joseph Johnson traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3207 Magnolia Avenue Baltimore, Maryland 21227 Vincent Evans Son permit. Pages 1 and Department of Healt Important: If item 2' any Injury or other once. Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 ☐ B**X**rial 2 ☐ Cremation Baltimore, Md 07/13/07 4 ☐ Donation 5 ☐ Other (Specify) **Baltimore National Cemetery** 22. Name and Address of Facility 21. Signature of Funeral Service Lic Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, of complications that caused the deat shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of) Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examiner that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Physician/Medical the for use as 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death P.0. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Tinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No 24a Was an autopsy performed? Yes 22 No certificate has page 2 s Yes Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one director Hospital: Other: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After Injury Natural (Month, Day Year) Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No M ithin 24 hours after death.

o the Funeral Director: A
ompletely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physiciam. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signa d title of c rtifie ure 2 of death (Item 23a) (Type, Print distrar's Signature 31. Date (iled State 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day  $\mathbf{P}^{\ M}$ **Physician** Margaret Maxine Eagan July 2007 7:31 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year)
Jan. 24, 1913 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Pennsylvania 342-50-2102 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hyglene. annert of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a nor 28a-f show up or or other traumatic event, the Medical Examiner must be notified at ury or or other traumatic event, the Medical Examiner. 1 ☐ Yes 2 XNo Director Maryland Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1055 West Joppa Road #113 21204 U.S.A. Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Grange Thomas W. Grady 2 19a. Informant's Name/Relationship (Type Print) hter-in-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trauonce. 11309 Ridermark Road Columbia, MD 21044 Lindell C. Eagan law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Lorraine Park Cem. 7-10-2007 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Witzke Funeral" Homes, Inc. bece 5555 Twin Knolls Road Columbia, MD 21045 23a. Part T. Ehter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eap viine. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as yo nsequence of): Physician disease or condition resulting in death) /Medical Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by brilla koi 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an , page 2 has autopsy performed certificate Yes 2 11 25. Was case referred to medical examiner? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**0**No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 2 28a Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannes of Death Certification: 5 ☐ Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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DHMH 17 Rev 1/2001

Baltimore,

P.0.

Records,

Division or Vital

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause

001

2007

Year)

701 N.

32 Registrar's Signature

f death (Item 23a) (Type, Print)

**ORIGINAL** 

D0030717

Charles St Sule 5201, BOOHNOLOMO 21204

		For State Registrar	0.0.0		Cei	rtificate o	Deatl	h		Reg. No.	2007	2220
Physic /Medi		1. Decedent's Name (First, Middle Roland E. En							2. Date of De Month	eath Day 8	Ź00 z	3. Time of Death 3. 10:41 M
Exami		4a. Facility Name (If not institutio Union Memori					imore	: City			County of Deat	
Funeral Director		5. Social Security Number 217–56–3688	6. Sex 7. Age 1	56 (In yrs. las	st birthday) Yrs.	If Under 1 Yea Months Day	r If Under	er 24 Hrs. Min.	8. Date of Bi July 2	8,19	50 9. Birt Co Mai	hplace (State or Foreign ountry) ryland
I e, INIAI y IAI IN ZILLISTOOOO  8 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	leted by Funeral Director	Usual Residence of Decedent  10a. State  Md. 10b. County  HOWa  10e. Street and Number  3147 Kings Co  11. Marital Status  1 Never Married 2 Marital Status  3 Widowed 4 Divorced  (Specify only higher	rd  12. Was Decedent I Armed Forces? 1 □ Yes 2 □ If Yes, 6! If Yes, 6!	Ever in U.S.	. 13. 1	10f. Zip Code 210 Was Decedent or If Yes, specify Co	42 Hispanic Claudin, Mexico Special Upation	fy:		30-	USA  14. Race - Ame Black, Whit  Specify: White	nican Indian, e, etc.
raild Z I Z  uld be filed withir  Aental Hygiene.  rked other than  tic event, the M	To Be Completed	17. Father's Name (First, Middle Roland E. E		+)		Chief Pl	anner	ther's Nam	e (First, Middle hy Owe	e, Maiden		Maryland
i, IVICILY and 2 shou ealth and M n 27 Is man	-	19a. Informant's Name/Relation Regina L. Engl				ng Address (Stre Kings C						
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Meone.		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  4 □ Donation 5 □ Other (  21. Signature of Funeral Service	Specify)	cei	ro Cre		Inc.	7/10 Cility Han	cry H.W	Cato	e's Fam:	
bot 00, totale be executed // Medical Examiner bhysician and sthe burial-transit	Medical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undenying Cause (Disease or injury that initiated events resulting in death) Last	b	a conseque	ence of):		•		or respiratory	arrest,	·	Approximate Interval Between Onset and Death
ag ‡	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a' 9 □ Unknown	2 Fetal	death 3[	⊒Ectopic pregna ⊒ Other (specify)					23d. Date of de Month	livery Day Year
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by	Part II. Other significant condit	of STENIS	ut not resul	ting in the u	inderlying cause			1 24a. Wa	Yes 2 us an topsy formed?	24b. Were a prior to death?	o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of  s 2 No
lor Attending Physician: after death. Director: After this certification by the funeral director, I	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coulc	Hospital: 1	y Year)		of 28c. ly	Other: 4 ☐ njury at Vork? ☐ Yes 2	Nursing H	ome 5 Received	sidence e how inju	nd Number or Fl	ecify) Tural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only 2 Medica one)  29b. Signature and title of certifi	ing Physician: To the best il Examiner: On the basis of and manner st	f examinati	vledge, dea on and/or i	nvestigation, in n	ense numbe	death occu	irred at the tim	e, date an	s) and manner and place, and du	e to the cause(s)
S Regis	_	30. Name and address of person address of person and address of person and address of person and address of person address of person and address of person address	HARCES IN	leath (Item	701 N	Print) S. Cuv	les 5	St	70W5U^	v м;	2120	4
					OR	IGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** LEE AMUEL 2007 25 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BAIHMER AVE ALL MANGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign / Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days 14 8006 223 Director JUNE 16, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State BAITHOR Tokes 2 No Completed by Funeral Director MNY /s.s. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 JUNGWAY 3571 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No If Yes, Give Year or Dates: WWZ 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes No Specify: Baltimore, Maryland 21215-0036 Specify. Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) penter BE GRECK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mc allough WILLIAM tuE11 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) SUND St. 1601 Baltonois TUDDAG 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Owings Miss mrism 22. Name and Address of Facility TM AN - HAVIO TOKA 21. Signature of Funeral Service License Le KeisTerstrus Baltopari, Ad 2/2/1 lake 23a Part1. En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme e Cause (Final isease or condition resulting in death) **Physician** /Medical Examiner eelensior Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or as a consequence of or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably **M** Unknown 24a. Was an autopsy perform 1□ Yes VZ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes No ျှ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

3 Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nojana 2009, 821 N. Eutaw Street, #308, Baltimore, MD21201

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month RACHEL **FRIEDMAN** JULY 2007 9:01 P 8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 16 OLD COURT ROAD APT. 504 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 X 172-14-0764 88 PA 12/03/1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE BALTIMORE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 16 OLD COURT ROAD APT. 504 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, et 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No WHITE Specify. 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MERCHANT SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MAX LEDERSTEIN **ROSE** BERMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON MAIER / DAUGHTER 3728 SPRING LAKE LANE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ■ Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify) BNAI JACOB CONG. 07/10/2007 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Sen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mon the Sillary Due to (or as a cons - uence of) Sequentially list conditions, if any, leading to immediate cause. Enter I Indert, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Healith and Mential Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or any fully or other traumatte event, the Medical Examiner must be no

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

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the Maryland

Examine as the burial-transi Physician/Medical Completed by Be ို Certification:

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

(Check only

29b. Signature and title of certifie

29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate ģ

Division or Vital Records, P.O. Box 68760.

the

State Registrar

Medical

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 Old ( Court

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 200 Robert John Fabriziani /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Levindale Hebrew Geriatric Ctr&Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min M 2□F Months Days Hours Director 08/23/1925 214-22-9533 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County r 28a-f show notified at show 1 Yes No Director MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. In the Mental Hygiene intit if fiem 27 is marked other than "natural", or items 23a or 3 and 10 or other traumatte event, the Medical Examiner must be not or other traumatte event, the Medical Examiner must be not or other traumatte event, the Medical Examiner must be not a context or or other traumatters. 5 Brett Ct. Apt. 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Abacus Elementary/Secondary (0-12) College (1-4or 5+) Security Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fabriziani Unknown Mary Unknown ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Jane Cochran/companion Brett Ct. Apt. 101 Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important; If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jul 11 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory Inc. 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dronos /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last hei Due to (or as a consequence of) Examine The law requires that the death certificate be executed pertension physician and s the burial-trans Due to for as a consequence of): Physician/Medical use as t as been signed by the attending pages as a should be detached for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 66 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 1∐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 patient မ 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of Injury (Month, Day 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Year. Injury M 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

Records, P.O. Box 68760. Division or Vital

after death hours a Hospital

n 24	edi	one) and manner stated.				
Vithii Som	Ž		License number	29d. Date signed (Month, Day, Year)		
		Weller Wester 5	23767	July 10, 2007		
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	$\Omega : I \cap \Omega$	0:01		
)		Jelia/Nerthemano 2434 Wel	Elveder the	Fath. 1 N 21215		
s	tate	31. Date filed (Month, Day, Year) 2007 32 Registrar's Signature	,			
Regis	trar					

29a. Certifier

Sa

tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle Le **Physician** Kichar 2 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner INAL 8. Date of Birth (Month, Day, Year) 2-12-49 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min 215-52-3979 1**X**M 2□ F Director land Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Hmore 10e. Street and Number 10g. Citizen of What Country? 23a or 2 212 Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 MYes 2 □ No If Yes, Give American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 'natural", or 1 ☐ Yes 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) eaven and Mental Hygic Is marked other 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last, Be pe 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau HO MI) 21206 Baltimore, 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 21. Signature of Funeral Service Licensee M0136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician all /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No 24a. Was an page 2 s has autopsy perform certificate 2 No 1∏ Yes Division or Vital Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Be 21 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Nnpatient 2 ER/Outpatient 3 DOA ္ရ this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrar's Signature

2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 Year **Physician** MELVIN C. GRIFFIN JULY 9 3:45A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HCR MANORCARE - ROLAND PARK CITY N/A BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1፟፟፟፟M 2□F Yrs. Director 217-26-1582 73 11/27/1933 MARYLAND Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 1 Yes 2 No N/A Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2617 WOODLAND AVENUE 21215 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? US 1 ☐ Wes 2 ☐ No US If Yes, Give ARM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 72 hours after 1 Never Married 2 Married ARMY 1 ☐ Yes 2 X No Specify: Specify: BLACK 3X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. GENERAL MOTORS College (1-4or 5+) Elementary/Secondary (0-12) FACTORY WORKER CORPORATION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi and Mental F Is marked ot WILLIAM GRIFFIN BETTY BORCO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is in any injury or other treum once. MARBETH GRIFFIN / DAUGHTER 3523 AILSA AVENUE, BALTIMORE, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 7/16/07 CATONSVILLE, MD METRO CREMATORY 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician LUNG CARCINOMA METASTATIC disease or condition resulting in death /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. cate has been signated by DIABLES MZLLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? 2 1 No 1 🗌 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Cther: 4 ☐ Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending | Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel within 24 hours a To the Funerel D 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D 5059107 F-10-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BUSINESS CENTER DRIVE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #1.perMD.C869, 7/17/07 TT Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 18:03PM Elliott L. Green, Jr. JULY 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Hospital Baltimore Sinal Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 65 Months 6689 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10b. County 10a. State 28a-f show 1 Pres 2 No notified Director 10g. Citizen of What Country? 10e. Street and Number a or Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ 100 No 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Black or 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced natural", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DONOT use retired) Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical 2121 College (1-4or 5+) than Elementary/Secondary (0-12) Hygiene. and Mental Hygie 17. Father's Name (First, Middle, Last) Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be should be ပ 19b. Mailing Address (Street and Number or Rural Route Num ity or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hella Li Grun and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Baltimore. 20b. Place of Disposition (Name of Cametery, crematory or other pl 20a. Method of Disposition Pages 3 ☐Removal from State 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Lournal Pike Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 7 days ARDS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for 1 in the past 12 months? 1 ☐ Yes 2 ☐ Yo 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown INTERSTITIAL LUNG Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an TOI autopsy performed? (es 2 No page 2 2 No 1 ☐ Yes certificate 1∏ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Impatient Certification: To this 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death.
Funeral Director: A etely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2FS-000 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE SINAI KUMAR MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ECN

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(9)

No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) GRAVES WILLIAM 2007 640 A M JULY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HOSPITAL BALTIMORE HARBOR N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1□₩ 2□F Jan 27, 1918 Maryland 220-01-8165 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Wes 2 ☐ No **Baltimore** N/A Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21225 1363 Spellman Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 🗷 ¥o Specify Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Supply Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown William L. Graves, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1363 Spellman Road Baltimore, Maryland 21225 Rena Drummond 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Kgurial 2 □ Cremation 3 □ Removal from State Fountain, Maryland 4 Donation 5 Dother (Specify) Big Woods Cemetery 21. Signature of Funeral Service Dicemee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death one enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) ENCEPHALOPATHY Due to (or as a consequence of): 3 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

the burial-transit death certificate be ned by the a sign be ( has page or Attending Physician:

Division or Vital Records, P.O. Box 68760

Physician/Medical Examiner

Completed by

Medical Certification: To Be

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SOUTH

JUL 1 1 2007

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery  Month Day Year					
RHELIMAT	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Yunknown					
HYPERTE	NSIONI	24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No					
25. Was case referred to medical	26. Place of Death (Check only one)						
examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1   Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)						
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	( <i>Month, Ďay Year</i> ) Injury Work? n M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)					

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES 000

IND BEBU DANA BALTIMORE, MARYLAND 21225

29d. Date signed (Month, Day, Year)

State Registrar

within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu To the Hospital

PHYSICIAN

2. Registrar's Signature

STREET,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANOVER

			For State Registrar	Otate of Mary		ertificate of L			eg. No. 7	22216
Ī	Physicia	_	1. Decedent's Name (First, Middle, Las Elizabeth	t) A.		Graves		2. Date of Dear Month July	Day Year 07 2007	3. Time of Death 6 · 23 P M
/Medica Examine		- 4	4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death Baltimore			4c. County of Death NA	
	Funeral Director		5. Social Security Number 6. Security Number 11	ex	In yrs. last birthday 56 Yrs.	Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)		place (State or Foreign intry) Md •
ore, Maryland 2	Maryland -f show led at	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Baltim		0c. City, Town or L	ocation lallstown				10d. Inside City Limits  1 Yes 2 □ No
	h with the 23a or 28a st be notif	Funeral Director	10e. Street and Number  1 Elwell Court			10f. Zip Code 211:	33	1	Og. Citizen of What Cou USA	intry?
	be filed within 72 hours after death with the Marylar ttal Hygiene. sd other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify: B	lack
	d within 72 ho giene. er than "natui , the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12 grade	lucation de completed) College (1-4or 5+)	(Giv	edent's Usual Occup ve kind of work done DO NOT use retired	during most of work i) surance C	laims		ndustry —Blue Shield
	should be file nd Mental Hy marked othe imatic event	To Be (	17. Father's Name (First, Middle, Last) Nesbitt		ckson		Sarah		Maiden Surname) Jone	
	and 2 sho ealth and n 27 is mi		19a. Informant's Name/Relationship (7) Ronald Buckson	Brother	320	7 The Ala	meda , Ba	ltimore		8
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specification)	y)	Garriso		vet 7-1		Owings Mil	
pall	permit. Page Department of Important: If any injury of		21. Signature of Funeral Service Licer	Mhltz	rely	22. Name and Addre	North Ave	., Balt	.H. East imore, Md.	21202 Approximate
Records, P.O. Box 68/60, Co	Physician /Medical Examiner	iner	23a. Pa 1. Enter the disease, or com sh c , or heart failure. List only Imme rate Cause (Final disea e or condition resulting in death)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying	- Lu	ny Can					Interval Between Onset and Death Onset and Death Worth Harry weeks
	ie be executed /sician and e burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):	y Fai	lure			
	he death certificate the attending physi ched for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	☐ Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of del Month	ivery Day Year
	w requires that the de been signed by the s should be detached t	by	The state of the s						obacco use contribute to ¶es 2  No 3  Pr	
	The law rec	Completed						24a. Was autop perfo 1□ Yes	prior to death?	utopsy findings available completion of cause of
Vital	nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient		in all post Ott	26. Place of Dea			-/6.1
Division or	ttending Physicath. tor: After this the funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	t 2 ER/Outpat 28b. Time Year) Injur	e of 28c. Injury at 28d. Describe how injury occurred					
	by by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specify)			street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	Medical C	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e	examination and/or ed.	r investigation, in my	opinion, death occu	rred at the time,	date and place, and du	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	m - 1	/) -	29c. Licen	se number 243894	16	29d. Date signed (Monity UT)	h, Day, Year)
,	b		30. Name and address of person who Rotter Note File		ath (Item 23a) (Typ	pe, Print)	night of a	1 110	s p; tal	
		ate rar	31. Date filed (Month, Day, Year)	2007 32. Fegistrar	's Signature	Sparke	, , , , , ,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 08,2007 5:25 Patsy D.M. Green 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Essex | If Under 24 Hrs. | Min. Baltimore 1037 Foxridge Lane Social Security Number 6. Sex 8. Date of Birth (Month, Day, 03.17. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number 1 □ M 2 🗸 F 1943 MD 216.42.9280 64 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 1 ☐ Yes 2 No Essex MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Essex 1037 Foxridge Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Bowen Leonard Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Alexander/Friend 1037 Foxridge Lane Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07.10.07 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto. 21. Signature of Funeral Service Licensee 401443 Alternatives 8717 Green Pastures Dr. MD 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage R Due to (or as a const uence of): Renal Disease years Mellitus, Type I Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident Injury

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If Item 27 Is marked other 1 any Injury or other traumatic event, #

**Physician** 

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

Director

Funeral

ģ

Completed

Be

Examiner Physician/Medical use as 2 Completed Be P Certification:

physician and s the burial-trans sate has been signed by the a page 2 should be detached

Division or Vital Records, P.O. Box 68760,

or Attending Physician: To the Hospital o within 24 hours aff To the Funeral Di completely filled in

10

State Registrar

Medical

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of prtifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Kichard 31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

m.D.

7600 OslerDr., Suite311

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	Re	gistrar	Of Bodin	2. Date of Death	3. Time of Death			
hysician. Examine		Decedent's Name (First, Middle,Last) Blane Herbert Garrett		Month Day July 3, 2007				
ZXamme	-	a. Facility Name (if not institution, give street and number) 11 W. 20th Street, Apt. 18G	4b. City, Town, or Locati Baltimore		4c. County of Death			
Funeral Director	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday	,	Ours Min. 01/05/	M/DD/YYYY) 9. Birthplace (State or Foreign Country) MD			
w any	_	sual Residence of Decedent  0a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 Yes 2 N			
with the Maryland ms 23a or 28a-f show be notified at once.		Oe. Street and Number 11 W. 20th St. Apt.18G	10f. Zip Code 21218	10g. C	Citizen of What Country?			
13-UU36 filed within 72 hours after death with the Maryland I Hygiene. Hygiene than "natural", or items 23a or 28a-f she to the Medical Examiner must be notified at once	<u>e</u>   1	1. Marital Status 1. Married 2 Married 2 Armed Forces? 13.	If Yes, specify Cuban, Mex		14. Race - American Indian, Black, White, etc.			
ours after de latural", or	⋧┞	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)	Yes 2 No speedent's Usual Occupation (Ong most of working life. DO	Yes 2 No specify: Specify: Specify:  's Usual Occupation (Give kind of work done st of working life. DO NOT use retired)				
5-UUSO led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 10 unk  17. Father's Name (First, Middle, Last)	nown  18.Mother's Name (First, Middle, Maiden Surname)					
d be denta fenta even	မ္က	Joseph Herbert Garrett  19a Informant's Name/Relationship (Type, Print)  19b. M	ailing Address (Street and	anita Diane I	r, City or Town, State, Zip Code)			
and 2 should and 2 should dealth and Me teem 27 is ma traumatic ev	-	Nikolai Garrett/brother   30		2St.Baltimor	e , MD 21218 Oc. Location - City or Town, State			
Palitimore, Min 2121 permit Pages 1 and 2 should be fit Department of Health and Mental 1 Important: If item 27 is marked injury or other traumatic event,		1 Burial 2 Peremation 3 Removal from State Chesap	isposition (Name of cemeter or other place) eake Crem.	7-7-2007	Beltsville,MD			
Salulii ermit Pa Separtmer mportan njury or		21 Signature of Funeral Service Licensee	22. Name and Address of F	acility Cremation + Fu stures Or. Towson	ineral Atternatives			
/sician	4	23a. Part I, Enter the disease, or complications that caused the death. Do not en	nter the mode of dying, such	h as cardiac or respiratory arrest,	Between Onset a			
ical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  The condition resulting in death of the condition resulting in de	n and cocaine us	e	Death			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
executed an and al - transit	Examine	Cusease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d						
- o '5'E	dica	Y UNPENDED AME	G869, 7/13/07 T	<u> </u>	23d. Date of delivery			
<b>∞</b> ∃ ∃ ≅ l	Physician/Medical	4 Pregnant at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregnancy	Month Day Year			
tal Records, P.O. Box 6 rian: The law requires that the death cer certificate has been signed by the attenti ector, page 2 should be detached for use.		1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause give		acco use contribute to the cause of death  2 V No 3 Probably 4 Unknown			
rds, P. requires the been signed to deliber de	Completed by			24a. Was ar autopsy	24b. Were autopsy findings avai			
ecor he law ate has age 2 sh	omp	4		perform 1 ✓ Yes 2				
ian: 1	BeC	25. Was case referred to medical examiner? Hospital: Innation 2 FR/Out		Death (Check only one)  her 1 Nursing Home 5 R	Residence 6 🗸 Other: Scene			
of Vit ling Physic After this of funeral dire	4	1 V Yes 2 No Impater 2 28b. Ti	me of Injury 28c. Injury	at Work? 28d. Describe ho	ow injury occurred			
on o ending ath. or: Aft	tion	1 Natural 5 Pending Find 7/3/2007 Find	9:45 am	s 2 XNo unk	treet and Number or Rural Route Number			
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attenti completely filled in by the funeral director, page 2 should be detached for use.	Certification:	3 Suicide 6 X Could not be determined (Specify) found at ho	me	or Town, St. 11 W. 20t	h St. Apt 18G Baltimore			
the Hosp thin 24 ho the Fune	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, o	neath occurred at the time, date of	and manner as stated. and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)			
	Me	29b. Signature and title of certifier	29c. License O.C.M		July 4, 2007			
) per		30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 11	1 Penn Street, Baltir	more, MD 21201				
S Regis	tate	1111 4 4 7007 / 124	Smiles					
Megis	2004		IGINAL		OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 8Day July 2007 3:30 рм WALTER HOFT7FR IR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia 8943 Early April Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 31, 1939 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ★ M 2 🗆 F New York 67 Director 105 30 9929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 No **Funeral Director** Maryland | Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21046 United States America 8943 Early April Way 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No1962-1965 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Store Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Lyness Walter G. Hoetzer Sr. 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8943 Early April Way Columbia MD 21046 Faith Nielson / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 CCremation 3 ☐ Removal from State Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10 21. Signat Te Vi Juneral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring RD Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death

**Physician** /Medical **Examiner** Hospital .r Attending Physician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

nse atte for 1 detached signed to after death.

Division or Vital Records, P.O. Box 68760,

	disease or condition resulting in death)	a. Due to (or as a consequence of):	Callicel 10 months
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	
lical Exan	that initiated events resulting in death) Last	c	
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery  Month Day Year
ed by PI	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Complet			24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death; 1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)
10E	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 □Other (Specify)
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
dical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)
dical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, and inner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who complete

Year)

within 24 hours af

To the Funeral D

completely filled

To the

egistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** July 2ඊඊ7 ŏ4 Hamlin S. 4:31p. M Bobbie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Baltimore Home If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M X□ F Yrs Director 461-12-2360 90 05 08 OK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f ehow The Medical Examinar must be notified at 1√2 Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8513 Castlemill Circle 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 🎖 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If itam 27 ie markad othar the any injury or othar traumatic event, ITS ORG. 12th grade Secretary State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abert Hamlin Zadie Mae Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8513 Castlemill Circle, Baltimore, Md 21236 Byron Hamlin-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 7/10/07 Baltimore, Md 21. Signatura of Fundal Solvice Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Cardiovascular Immediate Cause (Final disease or condition resulting in death) remoscieration Physician reess /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed and Due to (or as a consequence of): the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Įo, in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by enen 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 ☐ No 25 No 1 Yes Hospital or Attanding Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this uneral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide fo tha Funaral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 2564 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Charles St Such 2009, 2. Registrar's Signature Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Wilbert 7:00p. M Thomas 2007 Hi11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care-Irvington Baltimore N/AIf Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□ F Director 219-03-1782 85 12-4-1921 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 1X Yes 2 No Director MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2325 Hollins Street permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Natural". 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: **Black** Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Meat Processor Park Sausage Elementary/Secondary (0-12) College (1-4or 5+) N/A llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Bell Laura Martin ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Dowell-Daughter 104 Village Pine Apt 3-B , Randallstown, Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Zion Cemetery 7-10-07 Lansdown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erasi /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Physician/Medical ası attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an certificate has birector, page 2 s autopsy performed? 2 No 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 💢 No ۵ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Box 68760, P.O. | Division or Vital Records, To the Hospital or Attending Physician: death. ours after death.

Filled in by the fi within 24 hours a

To the Funeral I

completely filled

State Registrar

Medical

Walen

29c. License number

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)\_

MAEEM.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 ☐ Could not be

determined



Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 17,19a, perInf, C869, 7/30/00 antificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Day Year Hesselback Marie /Medical June 2007 0245 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda, Mar Suburban Hospital Maryland Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year 06/12/1914 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Days Hours Min 93 Director 216-44-3500 Bronx. N Y Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits **Funeral Director** MD Montgomery 1X Yes 2 No Bethesda, Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5619 Oakmont Ave 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Completed by SpecifiGerman-American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bio-Chemetry N. I. H. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George C Hasselback Hesselbach 2 Marie Lieblein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5619 Oakmont Ave. Bethesda, Maryland 20817 K. Cornelia Hesselback(Sister) 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Howard Univ Med.Sch 6/26/2007 Washington, D C 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee Terry A Austin 3821 14th Street N W Washington, D C 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Restrietive Lung Diseas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗶 No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown Hesselbach, Mane 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes il or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes **2** √ No 2 1 XInpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1XXNatural 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063195 06/25/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q 8600 Old Georgetown Road, Bethesda, Maryalnd 20814 State 2007 11 The Baran Registrar

07-05184 William Harris

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Baltimore, permit Pages I at Department of He Important: If ite Injury or other tr	1	21. Si nature of Funeral Service	e Licensee	11/	1		lame and A					.H. Ea		21202	
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Division  To the Hospital or Attend within 24 hours after death  To the Funeral Director:	cal	(Check only one) Medical E	Physician: To the xaminer:On the ba	best of my kr sis of examin	nowledge, de ation and/or	eath occu investiga	irred at the ation, in my	opinion	ite and pia , death oc	curred at	the time, dat	e and place,	and due t	to the cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh e869 7-11-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 **Physician** 26 2007 Lavon Patricia Henson 2:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1827 W. Saratoga Street Baltimore If Under 1 Year | If Under 24 Hrs. Date of Brth (Month, Bay, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 K F Director 217-66-3380 45 MD Feb. <del>C,</del> 1962 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore Director 1 XIYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1827 W. Saratoga Street 21223 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2€2 No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African American þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housekeeping domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Henson Gertrude Johnson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1827 W. Saratoga Street; Baltimore, Maryland 21223 Gertrude Nock / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or otl
once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/30/2007 King Memorial Park Randallstown, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** 18m Sequentially list conditions, if any, leading to immediate cause. End of carry that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 多 Due to (or as a consequence of): Physician/Medical attending physic 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 ponths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 ☐ Yes 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes within 24 hours after death.

To the Funeral Director; After this certifies completely filled in by the funeral director; a 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ No 3□ DOA Medical Certification: To 1 | Inpatient 2 ☐ ER/Outpatient 5☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 🖸 Natural 2 🗀 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and time of conti 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 P 31. Date filed (Month, Day, Year) 32. Registrar's \$ignature State Registrar Beren &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per th 8869 7-11-07 Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day July 2007 2:30p. Johnson /Medicat Mary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director 219-38-8310 -05 WV Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director Y☐Yes 2☐No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or 3600 Liberty Heights Ave 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 🛣 ☐ No Specify: Black څ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hor Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical E any foce. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Music Educator Public Schools 5yrs± 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry P. Bundy <u>Clara Johnson</u> 19a. Informant's Name/Relationship (Type. Print)
Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Judith Laurice B.</u> 3333 Gabriel's Mountain Trail, Roanoke, Hampton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn 7/13/07 Baltimore Co, Md 21 Signatur of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 300 Wabash Ave, Baltimore, Md 21215 23a. Parta Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mm - diate Cause (Final is - ase or condition liting in death) Physician /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any sading to in modest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 1 ☐ Yes 2 ☐ No 2 A NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 ☐ Yes 2 ☐ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 - Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

the death certificate be executed P.O. Box 68760 signed by the a d be detached f Division or Vital Records, cate has been signated page 2 should b certificate this completely filled in by the funeral 24 hours after death. e Funeral Director: After Hospital or Attending To the To the within

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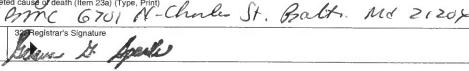
1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar 2007

(Check only one)

29b. Signature and title of certifier



no

and manner stated.

30. Name and address of person who completed cause o death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Medical

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 755AM **Physician** 10 Michael David Kurtz /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE-LIASHMATON Medical Levke Social Security Number 7. Age (In yrs. last birthday) Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 192-46-5869 February 5, 1954 Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 No Maryland Glen Burnie Directo Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number pe c 21060 7575 E. Howard USA ns 23a o Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Is marked other than "natural", or items raumatic event, the Medical Examiner mu 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell M. D. Kurtz Lott Josephine P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Margaret St. Baltimore, MD 21225 Rose Moulden 3725 Sister Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State July 9,2007 Harover, MD Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi 11h0815 Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached 9∏t Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To After this Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No thours after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier n who completed cause of death (Item 23a) (Type, Print)

State Registrar 30 Name and address of

31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

3 Registrar's Signature

Glen Burnie MD 21061

			For State Registrar		State of M	larylan			nt of H <i>te of L</i>		nd Me	ntal Hy	giene Reg. No./	ת מים כ	0000
	Physici /Medi		Decedent's Name (First  Edward	, Middle, Last)	F.	Κι	ıhlman					Date of De Month	eath Day	Year 2007	3. Time of Death 12:16 P M
	Examir		4a. Facility Name (If not in 3504 Orchar			)		·		Location of E	Death	•		County of Deat	h
	Funeral Director		5. Social Security Number 217–09–6561	6. Sex		ge (In yrs	last birthday) Yrs.			If Under 24	Min.	Date of Bi (Month, Di ulv 2	rth a <i>y</i> , <i>Year)</i>	Co	e  nplace (State or Foreign untry)  imore, MD
	and and		Usual Residence of Deced	lent County		10c. City	y, Town or Lo	cation				ary z	1 121	o parc	10d. Inside City Limits
	e Maryl a-f sho tified a	ctor	MD Ba	ltimore		Balt	imore								1 ☐ Yes 2 🙀 No
	with the	Funeral Director	10e. Street and Number	J 7	_			10f. Zi	p Code					en of What Co	untry?
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960	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 3 🔀 Widowed 4 ☐ Di		Armed Forces'  1 X Yes 2 ☐  If Yes, Give 1  Year or Dates:	No		lf Yes, sp∈ 1 □ Yes		n, Mexican, F Specify:	Puerto Rio	can, etc.)		Black, White Specify:	white
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aryl	2 should and Men is marke sumatic	욘	19a. Informant's Name/Re	elationship (Type		illikari	19b. Mailir	ng Addres	s (Street a			Route Numb	ber, City or	Town, State, Z	
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nore	9 0 <del>-</del> -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cren	nation 3 □Re	moval from State	, ,	Place of Dispo cemetery, crer Ce View	natory or	other place		Date 1			cation - City or	Town, State
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Maryland	should be and Mental Is marked of eumatic eve	၉	19a. Informant's Name/Relationship (	Type, Print)	15	9b. Mailir	ng Address (Street	and Numbe	er or Rural R	oute Number	City or Tow	vn, State, Zij	o Code)	
			RUTH MCCORMICK	/ DAUGH	TER :	3914	SHENTO	ON RD	., RA	ANDALI	STOW	N, MI	21133	
ore,			20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐	Domoval from State	20b. Place ceme	of Dispo	sition (Name of matory or other plac ERANS CE	Ç0)	Date 7 / 1 2		20c. Locatio	n - City or T	own, State	
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	the I	Medical	one) 29b. Signature and title of certifier	and manner st			29c. Licens				9d. Date sig			
)	Z with Co.		MAPT A	1,20				249	70		TUL	4 9 5	2007	
1	7		30. Name and address of person who	completed cause of	death (Item 23:	a) (Type		, ~ 1 1	/ 0		7 -	( /)	27773	
U	V		CLIFF FABER Y	70 540	1020	CU	URS ROA	AD R	PANO.	ALLST	OWN	MAL	12800	
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	Physici /Medi		1. Decedent's Name (First, Middle, Last)	LINZ			of Death		3. Time of Death  10:40P M
	Examir		4a. Facility Name (If not institution, give street and number, 302 Valley Court Road	)	4b. City, Town, or Loc Timonium		40	Baltimore	
*	Funeral Director		217-62-4401 XX 2 F			Under 24 Hrs. 8. Date (Mont	h, Day, Year)	9. Birthplac Country Mary I	ce (State or Foreign
	laryland show ed at	j.	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	tion			10d	Inside City Limits
	or 28a-f	Direct	Maryland Baltimore  10e. Street and Number	Timonium	10f. Zip Code			tizen of What Country	1 □ Yes 2√√No √?
	death w	Funeral Director	302 Valley Court Road  11. Marital Status 12. Was Decedent Armed Forces'	t Ever in U.S. 13. Wa	21093	nic Origin? (Specify Yes lexican, Puerto Rican, etc		SA 14. Race - American	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.	þ	1 Never Married XX Married 3 Widowed 4 Divorced  1 Yes, Give Year or Dates:	<b>K</b> No 1 [	_ 1444	pecify:	)	Black, White, etc Specify: Whit	
21215-0036	thin 72 h le. an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	5+) (Give kir	nt's Usual Occupation nd of work done durin O NOT use retired)		16b. K	(ind of Business/Indus	itry
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Maryland	hould be id Menta marked matic ev	ToB	William Alfred Linz  19a. Informant's Name/Relationship (Type. Print)	19h Mailing	Address (Street and	Dorothy  Number or Rural Route N			ada)
	l and 2 s Health ar Im 27 Is ther trau		Ann Weitzman Linz Ann Weitzmann Linz	Wife 302 Val	lley Court	Road Timon	ium Ma	ryland 210	93
Baltimore,	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition  1 ☐ Burial 2XX remation 3 ☐ Removal from State  ¶☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispositi cemetery, crema GreenMount	tory or other place)	7/11/07		ocation - City or Towr timore, Ma	
Balt	permit. Depart Import any inj	_	2) Signature of Funeral Solvice Licensee  MMS DIEGNON KONG	akis 22.1		Facility Mitchell- York Road B			
	Physician		23a. Part1. Enter the disea A, or complications that cause shock, or heart failure. List only one rause on each Immediate Cause (Final	11 414			ory arrest,	l n	pproximate terval Between inset and Death
	/Medical Examiner		disease or condition resulting in death)  Due to (or as	s a consequence of):	ll Cerciu	surec		بكرد	rs. 8 mos.
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ital F		Be Con	25. Was case referred to medical		26.	Place of Death (Check of		death?	<b>S</b> No
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ision	ttending F death. Stor: After the funera	Certification:	1 Natural 5 □ Pending (Month, De 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 28a Place of investigation	a <i>y Year)</i> Injury jury - At home, farm, street	M 1 ☐ Yes	2 □No			
<u>&gt;</u>	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		4 ☐ Homicide determined building, e	tc. (Specify)		City c	r Town, State		
	To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best 2  Medical Examiner: On the basis of and manner st	of examination and/or inves	ccurred at the time, d stigation, in my opinio	ate and place, and due to in, death occurred at the	the cause(s ime, date and	) and manner as state d place, and due to th	e cause(s)
)	To the within 2 To the comple	Σ		CTOR, CAL ONCOLOBY	29c. License nur	_		te signed (Month, Da y 9, 2007	
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DHI	MH 17 Rev 1/2	001		6:-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2007 /Medical Linda Mae Lutman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAITIMORE (State Rosedale HOSPILA 8. Date of Birth (Month, Day, Year) 07/28/1952 Birthplace (State or Foreign Country)
 Maryland Social Security Number 6. Se **Funeral** 1 □ M 2 🛛 F Director 54 217-58-7545 Usual Residence of Decedent the Maryland a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. by Funeral 8 Heathrow Manor Court 21236 death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. i 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. 1 ☐ Never Married 2 X Married 21215-0036 "natural", or 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White Completed Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Optician LensCrafters is marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ John Edward Hipley Ethel Margaret Unkart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: if item 27 is any Injury or other trai 8 Heathrow Manor Court - Nottingham, Maryland21236 Ross H. Lutman (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Ind.07/13/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 11750 Belair Road - Kingsville, Maryland 21087 a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Physician Embolism resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2**X** No 1 🗌 Yes 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? r this certificate has ral director, page 2 autopsy performe Yes 2□No 2 No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) n Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

9000 DR WASSIM 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SqUARE DR. BAITIMORE Md 21237 FRANKLI

32/Begistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Elizabeth m.

to physicians

1 1 2007

		State of Maryl	•	artment of F		-	giene Reg. No.	
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Florence P. Luttermoser				2. Date of De Month  July	Day Year 1, 2007	8. Time of Death 11:18 AMM
Examin Funeral Director	er	058-36-7275 1□M 2K)F 92	yrs. last birthday) <b>2</b> Yrs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Brookevi If Under 24 Hrs Hours Min.	.11e	ay, Year)   Co	
ne Maryland 8a-f show xiffied at	ector	MD Montgomery E	City, Town or Lo	lle				10d. Inside City Limits 1 □Yes 2 No
ith with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 20529 Riggs Hill Way		10f. Zip Code 20833-			10g. Citizen of What Co	ates
urs after des al", or items Examiner m	by	11. Marital Status  1 □ Never Married  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever i Armed Forces?  1 □ Yes ≥ Yes No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💢 No	lispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. It health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Business. Own Home	
ould be filed Mental Hygi arked other atic event, ti	To Be Co	17. Father's Name (First, Middle, Last)  David C. Duey			Delilah	Waring	l , Maiden Surname)	
and 2 sho alth and 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print)  George W. Luttermoser/Husband	!				per, City or Town, State, . ville, MD 20	• •
permit. Pages 1 and 2 s Department of Health ar Important; if item 27 is any injury or other trau once.		1 Bunar 2 Cremation 3 Hernoval from State		osition (Name of matory or other place ake Crema		Date Jul 3 2007	20c. Location - City or Beltsville	
Physician /Medical Examiner	edical Examiner	23a. Part1. Enter the disease, or complications that caused the caused shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition or injury that initiated events resulting in death) Last  Due to (or as a condition or injury that initiated events resulting in death) Last	death. Do not en	ter the mode of dyir	ve. Silv	er Sprin	g, Maryland	Approximate Interval Between Onset and Death 30 years 30 years
*hysician: The law requires that the death certificate be exitis certificate has been signed by the attending physician all director, page 2 should be detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
requires that een signed by rould be deta	þ	Part II. Other significant conditions contributing to death but not	t resulting in the u	inderlying cause giv	ven in Part I.		tobacco use contribute to Yes 2 <b>X</b> No 3 □ P	o the cause of death? robably 4 □Unknowi
nn; The law ificate has b or, page 2 sh	e Completed	25. Was case referred to medical			26 Place of De	24a. Was auto perfi	opsy prior to ormed? death? 2€ No 1 □ Yes	utopsy findings available completion of cause of
or Attending F ifter death. Director: After in by the funera	Certification: To Be	examiner?	At home, farm, st	of 28c. Inju Wo M 1	ner: 4 ☐ Nursing I	Home 5 Res 28d. Describe	idence 6 Other (Spe how injury occurred (Street and Number or Fi wn, State)	
the Hospital hin 24 hours a the Funeral I	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my and manner stated.		nvestigation, in my	opinion, death occ		, date and place, and du	e to the cause(s)
With Con	Σ	29b. Signature and title of certifier  30. Name and address of person who completed cause of death	(Item 23a) (Twee	D266			29d. Date signed (Mon	
ر Sta	ate	Gary M. Milles MD 8186 Lock  31. Date filed (Month. Day, Year)  32. Realstray's S	Brown R	d. Elkric	lge MD 2	21075		
Registi	oo1	JUL 1 1 2007 June	J. J.	perte				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM/4a, perPHYS. 19a, 20c, perFH, G869, 7/11/07, WS

State of Maryland, Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician Year 4:00 AM 20 2007 /Medical (If not institution, give street and number 2902 Echodale Ave. number. 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 219-52-7023 1**X**M 2□ F Yrs. Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "netural", or items 23a or 28a-f ehov traumatic event, Ir e Madical Experient, ust be matified at Director 1 Yes 2 □ No HMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code le Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: as δ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Securitary (0-12) College (1-4or 5+) aith and Mental Hvo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Samame) Be Pages 1 and 2 should Annie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) phy-Bey 290 of Health chodale Ave, Basto ND 21214 27 : If item 27 or other to Baltimore, 20c. Location - City or Town, State Baltimore Date Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Department o Importent: If eny injury or once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee permit. Oreine Funeral Services bekild. Balto MD UZIZ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lancer VNO disease or condition resulting in death) MEATS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Due to (or as a consequence of): IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) o detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the funeral director, page 2 should be 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 3/ No 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

Baltimore VA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kimba

31. Date filed (Modern Da)

MD

32 Registrar's Signature

AV4176435 K15787

10 N Greene St

June 21

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTM// perPIXS C869 7/11/07 IS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death David **Figure 1** McNeal Sr. Day Month Year **Physician** 11:00 PM 06 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baitimore Bayyers

5. Social Security Number Center ito Medical If Under 1 Year | If Under 24 Hrs. | 8. | Months | Days | Hours | Min. | (1 Date of Birth (Month, Day, Birthplace (State or Foreign Country) last birthday **Funeral** Year) 219-40-515 1 XM 2□F Months Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No ma Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SF 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or iten 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □ Yes Specify: Completed by 10 3 Widowed 4 Voivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry -lanigan Elementary/Secondary (0-12) College (1-4or 5+) N 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CNeal ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Essex, G.MC mai 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) on Cem 7-11-07 Cansdavne md. Fred HILTON Pass uneral Service Ucenso 22. Name and Address of Facility 270 21. Signature P. march Funeral Home Baoto, md, 2,229 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition **Physician** Anoxic Brain 45 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SCIZLIVE Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine The law requires that the death certificate be executed physician and the burial-transi Diabetes Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) been signed by the s should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes page 2 s 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 DOA မ 1 🔲 Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural (Month, Day Year) Injury 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vim Fredericksen, Medical Docker July Ob, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Johns Hopkis Hospital, 600 North Walfe Street,
32 negistrar's Signature Kim traderickson maryland 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05108 State of Maryland / Department of Health and Mental Hygiene Cynthia Mercer Certificate of Death 1- For State Reg. No Registrar Time of Death 2. Date of Death Decedent's Name (First, Middle,Last Physician/ Month Day July 3, 2007 Mercer 1710 hrs Cunthia Medical Examiner 4c. County of Deatl 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore City** Sinai Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Country) Director 215.76.0048 М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Baltimore 23a or 28a-f show notified at once.  $\mathsf{MD}$ Director 10g. Citizen of What Country 10e. Street and Number Load 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. Marital Status White: etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Married Never Married Yes Black ö Yes 2 X No specify: If Yes, Give Year Divorced Widowed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Departure to Chealth and Mental Hygiene.
Important: If item 27 is marked other than "natural",
injury or other traumatic event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Facton 12th anade 17. Father's Name (First, Middle, Last) Mercer (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informanţ's N. me/Relationship (Type, Print Brenda L 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, MD Removal from State 1 Burial 2 Cremation 3 07/13/07 Donation 5 Other Specify ompassion Funeral Services 22 Name and Address of acility Signature of Funeral Service Licensee 23a. Part I. Enler the disease, or failure. List only Street Balta S. Stricker aplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ast only one cause of Between Onset and **Physician** /Medical Brainstem Hemorrhage Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): b. Hypertensive cardiovascular disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial -AMENDED b, PII, 27, perME, g869, 7/20/07 TI 23d. Date of delivery P.O. Box 68760, 23c. If ves, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown ģ Cocaine use Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy performed? death? 1 V Yes ✓ Yes 2 No certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be Other<sub>4</sub> Other: examiner? Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 FR/Outpatient 3 1 🗸 Yes Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 X Natural Yes 2 Pending Director: d in by the Investigation 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 5, 2007 O.C.M.E. OKPEND 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD State

OCME

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CHARLOTTE MUSE 21:19 M 05 2007 JUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER 8. Date of Birth (Month, Day, Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) . Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🗓 F Hours 64-780 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No Funeral Director 9 more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If the alth amended other than "natural", or Items 23a or 3 any Inlury or other traumatic event, the Mental Examiner must be not 21 2/ Was Decedent of Hisparlic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working jife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) (Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) arme 21. Signature of Funeral Service License 22. Name and Address of Facility oseph 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LEFT BASAL GANGLION INTRACRANIAL HEMORR Approximate Interval Between Onset and Death INTRACRANIAL HEMORRAGE **Physician** DAYS /Medical Due to (or as a consequence of): Examiner YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown cate has been signage 2 should b 1 □ Yes 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1□ Yes 2 17 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ■ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completely To the

> State Registrar

one)

29b. Signature and title of certifier

EMAMHOSSEINI 31. Date filed (Month, Day, Year) JUL 1

32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH GREENE STREET BALTIMORE MARYLAND

AU4176435 E17280

29d. Date signed (Month, Day, Year)

2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MANA 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALHAGE NIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Min | Month, Day, Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1PM 2□F Yrs. 217 56 5132 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show ns 23a or 28a-f shov must be notified at 1 XYes 2 □ No Director BALHHURE MARY LAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LEVINABLE ROAD USM 2/2/5 5106 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items: any injury or other traumatic event, the Medical Examiner my once. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 Employers 12th Grade HINISNER 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be +, 11 IARB MANN 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 2/2/5 19a. Informant's Name/Relationship (Type. Prigit) LEVINDAK 06 Ku mo MOTHER 169918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 22. Name and Address of Facility WA THINK 4 Donation 5 Dother (Specify) 21. Signature of Suneral Service Licenses Reis Tersteur Rims 23a. Part1 Enter the disease, or complications that caused the death. Do at enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the signed by the attending p 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an has autopsy performed? Yes 2 No 200 No certificate 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: within 24 hours after death. To the Funeral Director: After completely filled in by the funera (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide

State Registrar 29a. Certifier

29b. Sign

Certifying Phys

nd title of

2 ☐ Medical Examiner

DHMH 17 Rev 1/2001

to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lifton Herber M	·	1- For State Certificate of D			No. 201	17 2223
Physicia		Registrar		Reg  2. Date of Death  Month  I	Day Year	3. Time of Death
ledical Exami	ner	1 1 1 1 TOO IT CLEDEL 14 (OLYVIA		July 9, 2007	7	1221 hrs
			City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral			If Under 1 Year If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	
Director		218.36.9745 1XM 2 F 66 Yrs.	Months Days Hours Min	06.18	.1941 Foreig	puntry) MD
. Au	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show any d at once.	١	NID Anne Arundel Glen Bur	ni e			1 Yes 2 No
with the Maryland us 23a or 28a-f sho be notified at once	ecto	10e. Street and Number	Of. Zip Code	100	. Citizen of What Cou	ntry?
h the N 3a or	ä	6387-C Smithy Square	21061	14325	U.S.A	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Funeral Director	11. Marital Status  1 Never Married  12. Was Decedent Ever in U.S.  13. Was Decedent Ever in U.S.  14. Armed Forces?  15. Yes	ecedent of Hispanic Origin?(Sp specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	rican Indian, Black,
fter der I", or i		1 Yes 2 No	es 2 No specify:		Specify: 7	acil
ours af atural	d by		Usual Occupation (Give kind of of working life, DO NOT use ret		16b. Kind of Business/	Industry
11215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		1 1500		
-00. d withing giene.	mo	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Ma	mor + gage aiden Surname)	.5
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be C	Cliften H. Murphy	muth	Muffin	7	
21 should nd Me is man	P	19a. Informant's Name/Relationship (Type, Print)	ddress (Street and Number or			
를 걸 불 토 등		20a. Method of Disposition 20b. Place of Disposition	C 5mithy 5q	Date C	1/20 Dirnie 20c. Location - City of	<i>MD 91161</i> r Town, State
Nore		1 Burial 2 Cremation 3 Removal from State crematory or other				
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other Specify: 160nmont  21. Signature of Funeral Service Licensee 22. Nar	ne and Address of Facility VC	11.200T 1	greene une	rui serra
ii ii per m		Vaudan C. Harene 87.  23a. Part (Enter the disease, or complications that caused the death. Do not enter the	28 Liberty nd	handa	Istoun MI	0 31133
Physician /Medical		23a. Part () Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Between Unset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot wound of head  Due to (or as a consequence of):	×			Death
		Sequentially list conditions, b.				
	iner	if any, leading to immediate Due to (or as a consequence of):				
sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
50, te be executed ysician and burial - transit	ledical I	d. UNPENDED AMENDED				
60, ate be ohysici	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	ry
tox 6876 eath certificate attending phy for use as the b	ian/	past 12 months?	death 3 Ectopic pregn	ancy	Month	Day Year
Box 68760, e death certificate be the attending physic red for use as the bur	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Othe	r (Specify)			
Sion of Vital Records, P.O. Box 6876 Attending Physician: The law requires that the death certificat death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	by Pt	Part II. Other significant conditions contributing to death but not resulting in the unc	erlying cause given in Part I.		eacco use contribute to 2 ✓ No 3 Pro	
S, P quires t an sign	ed k			24a. Was a		utopsy findings available
cords, law requir has been s	Completed			autops	y prior to	completion of cause of
tal Rec ician: The l certificate l		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Y	res 2 No
of Vital Records, g Physician: The law requir nfer this certificate has been s neral director, page 2 should	o Be	examiner?  1 \( \forall \text{Y} \text{ Yes}  2  \text{No} \)  Hospital: 1 \( \text{Inpatient}  2  \text{ER/Outpatient} \)	Other		Residence 6 🗸 Othe	er: Scene
1 of V	-	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year)		28d. Describe h	ow injury occurred	
ion ttendi death.	atio	2 Accident Investigation Jul 9, 2007 1215 hrs	1 Yes 2 V No			
돌 a 월 a ː ː ː	Certification:	3 Suicide 6 Could not be determined (Specify) Multi-Family Ant	factory, office building, etc.	28f. Location (S or Town, St 6387-C Smith	treet and Number or R ate) <sup>,</sup> Square, Glen Burr	tural Route Number, City
1 = 1 = 1 = 1		29a. Certifier 1 Certificing Physician: To the heet of my knowledge, death occurre	d at the time, date and place, an			
To the Hos within 24 h To the Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
F 3 F 5	M	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	onth, Day, Year)
~		my mis	O.C.M.E.		July 10, 2007	
5		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 21201			
	tate	31. Date filed (Month, Day, Year) 32/Registrar's Signature	Y .			
Regis			<u> </u>		·	
DHMH 17 Rev 1/2	2001	ORIGINAL ORIGINAL				

Reginald Milburn
07-05174

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK	State of Maryland / Departme: 1- For State Certifical	nt of Health and Mental Hygiene te of Death	Reg. No. 2007 2223
Physician/	Registrar  1 Decedent's Name (First, Middle, Last)	2. Date of De. Month	ath 3. Time of Death
Medical Examiner		July 6, 20	
(	Aa. Faculty Name (if not institution, give street and number)     2554 Hollins Street	4b. City, Town, or Location of Death Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Min I Day Have Min	Sirth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	218-74-0367 1XM 2 F 48	Yrs. Months Days Hours Min. 12/17	1958 Country) MD
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	r Location	10d. Inside City Limits
· .	Partir	nove -	1 Yes 2 No
Maryland 28a-f show d at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho are other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	2013 Bryant Avenue  11 Marital Status  12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or N	
eath wi	11. Marital Status  1 Never Married 2 Married 12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
safter de iral", or uiner mu	or Dates:	1 Yes 2 No specify:	Specify: 6 CCC
hours 'natur Exami	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of work done uring most of working life. DO NOT use retired)	C 1 C
5-0036 ed within 72 hour. tygiene. other than "natu the Medical Exau Completed	12th	Stocker	Uw Corporation
5-00 lled wit Hygien I other the M	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle	Maiden Surname)
2121; ould be fill d Mental F s marked fic event.	Iga, Informant's Name/Relation hip (Typps, Print)	. Mailing Address (Street and Number or Rural Route N	lumber, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	Alice Hampton (Mother) 2		more, mb 2/2/7
re, l s I and f Heals If item	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Crematic Crematic Removal from State Removal from State Crematic Removal from State Removal from	f Disposition (Name of cemetery, Date bry or other place)	
Baltimo bermit. Page Department of Important: injury or oth	4 Donation 5 Other Specify:	Zion 7/12/200	TOWN SOUNCES
Baltin permit. Departm Imports injury o	21. • In ture of Funeral Service Licensee	22 to and Address of acity reene 1 4101 Edmondson Avenue	1, Batto, mD 21229
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or respiratory	arrest, shock, or heart Approximate Interval Between Onset and
/Wedical)	Immediate Cause (Final disease a. Heroin intoxication		Death
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,		
iner.			
ed Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
and and - tra	d.	NE 000 7/05/07 EE	
60, nte be ex hysician e burial		erME,g869, 7/25/07 TT	23d. Date of delivery
ox 68760 eath certificate be attending physical for use as the butter of	23b. Was decedent pregnant in the past 12 months?		Month Day Year
m യ ജയി	1 Yes 2 No 9 Unknown 9 Unknown		the second of death?
	>	g in the uncertying cause given in the city	id tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 ✓ Unknown
duires t		24a. W	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  In Directors. After this certificate has been signed by led in by the funetal director, page 2 should be detacted in the control of the funetal director.			utopsy prior to completion of cause of death? es 2 No 1 ✓ Yes 2 No
tal Rec	25. Was case referred to medical	26.Place of Death (Check only one)	
Vital B hysician: this certification.	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	outpatient 3 DOA Other Nursing Home 5	Residence 6 🗸 Other: Scene
of Vit Jing Physic L. After this of funeral dire		1 Yes 2 V No unle	inge now injury occurred
ivisior I or Attend after death Director: d in by the I	Accident Pending Fnd7/6/2007 FN 28e. Place of Injury - At home, f	01 8:30 am   28f. Locati	on (Street and Number or Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) Found on po		yn, State) Hollins St. Baltimore, MD
Divisi  Divisi  To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		eath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within 2 To the complete	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Dorma Minerti, MD.	O.C.M.E.	July 6, 2007
6	30. Name and address of person who completed cause of death (Item 23a)	444 Dann Street Baltimara MD 24204	
3	Donna M. Vincenti, MD Assistant Medical Examine  31 Date filed (Month, Day Year) 32 Registrar's Signature	r 111 Penn Street, Baltimore, MD 21201	
Sta Registr	ar JUL 1 1 2007 Mayer & An	<u>ubs</u>	
DHMH 17 Rev 1/200	OCME O	RIGINAL	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan	-	artment of F			one 0 0 7	22240
	· ·		1. Decedent's Name (First, Middle, Las	)				2. Date of Death _Month	Day Year	3. Time of Death
1	Physici /Medio		Madeline	W.		Murp		July C	DE 2007	0229 AM
	Examir	ner	4a. Facility Name (If not institution, give				r Location of Deat	h '	4c. County of Deat	n
			Union Memorial		a at histheau	Balt.	imore If Under 24 Hrs	8. Date of Birth	Q Birth	nplace (State or Foreign
	Funeral Director			™ 2\XF 84	Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear) Co	MA
			221-16-6720 Usual Residence of Decedent	04				10 24		NA
	how	. [	10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	the Marylan 28a-f show	cto	MD NA	<u> </u>	Balti	nore				ty∑Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		100	. Citizen of What Co	
	ath w	rai	830 West 40th		0 40.1		1211	Sanaifu Van au No	U . S . A	
	ltem Item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?	5. 13. 1	Yes, specify Cubi	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, White	
36	Ir, or	by	3√2 Widowed 4 □ Divorced	1		☐ Yes 2 No	Specify:		Specify:	Black
5-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f show fra Madical Examiner must be muffled at	ted	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occup	pation	ntring 16	b. Kind of Business/	industry
7	thin 7	Completed	(Specify only highest gra-	College (1-4or 5+)			during most of wo d)	, Ally		
2	ed wi	S	12th grade	4yrs		Writer	40.44.45.4.45	(5) 100 100 100	Privat	:e
Ind	tal H d off	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma	·	
<u>\sqr</u>	should be filed within and Mental Hygiene. s merked other than "umatic svent, Ire Was	ဥ	Arthur Wheeler	ivan Drintl	10h Mailin	a Addraga /Straat		ine Hall		(in Code)
Maryland	OI 10 E	0 8	19a. Informant's Name/Relationship (7							
	1 and 1 Health tem 27		Laura W. Murph 20a. Method of Disposition	- 20b. P	face of Dispo	sition (Name of		Date 20	Shingtor oc. Location - City or	DC 20015 Town, State
Baltimore	permit. Pages 1 and Department of Heali Importent: If Item 2 eny injury or other once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	•	natory`or other pla		/11 /2003	F-161	M a
Ħ	artme orten injuri		21. Signature of Funeral Service Licen	1115	22	Name and Addre	ss of Facility	/11/2007	Balting	re, Ma
Ba	permit. Departr Import eny inj		1 Alma A	. Thompan	Ma	arch F/	H West ash Ave	, Baltim	ore, Md	21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death						Approximate Interval Between
	Physician	14 1	Immediate Cause (Final	A - A	i P.,	05 1 1 125 × ./ 0				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence)		EUMONI				7 71047
	Examiner		Conventially list conditions	Stroke.						20 years
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					///
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Hyperten.	SION					70 years
8760,	death certificate be executed e attending physician and od for use as the burial-transit	Ē	in dodain, date.	Dia La ta						40 years 40 years 40 years
87	cate l physi the b	Physician/Medical		d. DIADELE						10 years
9 X	that the death certifics ed by the attending pl detached for use as t	/Me	IF FEMALE:	23c. If yes, outcome of pregna	incy				23d. Date of del	ivery
Box	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d		Ectopic pregnanc Other <i>(specify)</i> _	y 		Month	Day Year
O.	the d by the	isk	1 □ Yes 2 ■ No 9 □ Unknown	9 Unknown						
٩,	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	quire n sig uld b	pa pa						1 ☐ Yes	2 No 3 □ Pr	obably 4 □Unknown
Division of Vital Records,	awre is bee 2 sho	Completed						24a. Was an autopsy	24b. Were au	topsy findings available
Ä	The law ate has I page 2 s	E						performe 1 ☐ Yes 2	d? death? No 1 ☐ Yes	completion of cause of
ita	ian: artifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)		
>	Physician: r this certific ral director,	2	1 ☐ Yes 2 X No		ER/Outpatien	1 3LI DON		Home 5 ☐ Residen		cify)
٦	ing P Viter t unera	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe how	injury occurred	
Sio	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		amo form etc		Yes 2 □ No	28f Location (Stre	et and Number or Ru	ıral Route Number
Σ	or Al	Certification;	4 ☐ Homicide determined	building, etc. (Specify	y)	eet, tactory, onice		City or Town,	State)	nar riogio rianiboli
_	points ours werel filled	S E	29a. Certifier Certifying Ph	ysician: To the best of my kno	wledge, death	occurred at the ti	me, date and plac	e, and due to the cau	se(s) and manner as	stated.
	the Hospital nin 24 hours a the Funerel npletely filled	Medical		iner: On the basis of examina and manner stated.						
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Monta	h, Day, Year)
			MO Haran	WIT MA	7	Do	70640	70	8 ml:	2007
	15		30. Name and address of person who	completed cause of death (Iten	n 23a) (Type,	Print)			7	21118
_	1	11.35	Allison L-Hobel	am ansen	2019	CUNIL	sity P	Kung Bal	Jand.	bealine
ν.	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	4)	)	0		
	Regist	rar	ANT II SAO	Million D.	No. Com					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 July 1:02 Leo T. McMahon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 1**X** M 2□ F New York 89 08/22/1917 Director 062-14-6457 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Glen Arm 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 11630 Glen Arm Road 21057 Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: WW II Specify: ģ 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the once. Tech Writer Edgewood Arsenal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Clifford McMahon Lucy McMahon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William T. McMahon (son) <u> 11716 Franklinville Road - Upper Falls,MD</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 XOther (Specify) Crypt Highview Memorial gdns.07/11/07 | Fallston, Maryland 21. Signa ur of Funeral Service Licen ee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21087 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Elone /Medical Due to for a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown benign page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed2 Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 21 No 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 A latural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

ORIGINAL

6535 N-82. Régistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** MARIANNE P. MURPHY 12:44PM JULY 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD **BELAIR** If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Mar. 31,1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months 1 □ M 2 🗙 F Mar. Maryland 217-40-2211 64 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes XX No Director Maryland | Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 923 Delray Drive 21050 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. WHITE Specify: Completed by XX Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. 12 yrs. Baltimore Archdiocese Payroll Administrator yr. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Buccheri Gustav Pastorious ೨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 201 Spectacular Bid Dr. Havre deGrace, Md. 21078 Stephen Murphy (Son) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Important: If it any Injury or o once. MXBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 7-9-2007 Baltimore. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licers 22. Name and Address of Facility Name and Address of Facility LASSAHN FUNERAL HOME 7401 Belair Rd. Raltimore Md. 21236 acockn Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner inding physician and use as the burial-tran Mwphy, Marianne MSOO4744 Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No DIFER 24a. Was an cate has page 2 s autopsy certificate 1 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident I Director: / 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital o within 24 hours aft To the Funeral Di 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66102

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

OO upper Chesapeake Dr. Beldir, MD 21014

30. Name and address of person who completed gause of death (Item 23a) (Type, Pyr

32

Registrar's Signature

31. Date filed (Month, Day, Year)

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event."

and ed by the a detached f within 24 hours a To the Funeral L

MARTIN

Division or Vital Records.

23a Part 1 Enter the disease, of o sbock, or heart failure. List or	molications that caused the deally one cause on each line.	th. Do not enter the mode	of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	UROSEP	SIS				2 Weeks
resulting in death)  Sequentially list conditions,	Due to (or as a consect b. PNEUMO)	quence of): NIA			2	Weeks
if any, leading to immediate cause. Litter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. CARDIOM  Due to (or as a consecutive to consecut	YOPATHY	_		2	2 Weeks
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	d	al death 3□Ectopic pre			23d. Date of deliver Month	y Day Year
Part II. Other significant condition	s contributing to death but not re	sulting in the underlying ca	use given in Part I.	23e. Did tobacco u  1  Yes 2	No 3 Proba	ably 4 Unknown  ssy findings available apletion of cause of
25. Was case referred to medical examiner?				eath (Check only one)		
1 ☐ Yes 2 💢 No	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐ DO/	Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify	)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigat  3 Suicide 6 Could no	28a. Date of Injury (Month, Day Year) ion	28b. Time of lnjury M	lc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred	
3 Suicide 6 Could not 4 Homicide determine		nome, farm, street, factory, ify)	office	28f. Location (Street an City or Town, State	d Number or Rurai )	Route Number,
	Physician: To the best of my kn caminer: On the basis of examin and manner stated.					
29b. Signature and title of certifier		29c.	License number	29d. Da	te signed (Month, I	Day, Year)
Tinta Punna	m MD	f	19925	1 .70	JL, 07,	2007

State Registrar

900 S. CATON AVE,

BALTIMORE,

MD

21220

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PUNNAM

Year)

JYOTHI

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Mjddle, Last) 2. Date of Death 3. Time of Death Month 07 **Physician** MCCAULEY 19.16 PM 00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CARROLL HOSPITAL CENTER CARROLL WESTMINSTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 23, | 5. Social Security Number ige (In yrs. last birthday) 9. Birthplace (State or Foreign Sirthpiac Country) WV **Funeral** Months 232-42-6786 1 □ M 2**X** F 78 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director MD Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2025 Flag Marsh Road 21771 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) item 27 Is marked other than "natural", or items other traumatic event, the Medical Examiner mo 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ☐Yes **2**K☐No Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental in item 27 Is marked of Francis Hughes Beatrice Smith ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Lee McCauley (Spouse) 2025 Flag Marsh Road Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or of Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Morgan Chapel Cemetery 7/13/2007 Woodbine, MD 21. Signature of Funeral Service License HAIGHT FUNERAL HOME & CHAPEL, PAA. (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LEURA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed NEUMO THORAX burial-tran Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Inknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 X No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Hospital: ٩ 1 N Inpatient 2 □ ER/Outpatient 3 □ DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

39. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANU. 3233 31. Date filed (Month, Day,

Homu



821. BOWIE, MD 20715

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	Physicia /Medic	al .				wski		r.				JUL	Y, 9 E	1007 8:48AM	
	Examin	er	4a. Facility Name (If not institution, g Saint Jose	ive street and number) ph Medica	l Ce	nter	4b. City,	Town, or	Location	Tow	son	40	County of De	eath laltimore	
M.	Funeral		5. Social Security Number 6. 215 - 52 - 4075	Sex 7. Age 1 XM 2 F	e (In yrs. la	s <i>t birthday)</i> Yrs.	If Unde Months	r 1 Year Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bi (Month, Di Oct29	rth ay, Year,	9. E	Birthplace (State or Foreign Country)	
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	fter de ritem Iner i	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 24 □ V							ecify Yes or N Rican, etc.)		Black, W	hite, etc.	
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Z	filed v Hygie ther 1		12th 17. Father's Name (First, Middle, La	st)		Plai	nt T	<u>ecn</u>	18. Mot	her's Name	e (First, Middle			& Gamble	
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ore	ages 1 int of Hi t: If iten / or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Removal from State	20b. Pla	ace of Dispo emetery, crei	sition (Na natory or	me of other plac	e)	-	Date		-	or Town, State	
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Dalt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic	Mary	_									ral Home,PA 1d. 21222	
ı	<i>‡</i>		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lir	the death. ne.	. Do not ent	er the mo	de of dyin	g, such a	as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in dealing	Due to (or as	a consequ	ence of):									
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	certific oding p	/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy								001 5 11 1				
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VII	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?												
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INISION	or Atter ifter deal Director in by the	Certification:	3 Suicide 6 Could not determine		ury - At hor c. (Specify,	me, farm, str	reet, factor	ry, office			28f. Location City or To			Rural Route Number,	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Ex	Physician: To the best aminer: On the basis o											
	the hin 24 the F	Medical	one)	and manner sta		1									
	To vit	=	29b. Signature and title of certifier  29c. License number  D32110								29d. Date signed (Month, Day, Year)				
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			30. Name and address of person		eath (Item			OSLI	ER I	DRIVE	E TOL	ISON	. MAR	YLAND 21204	
	Sta	te	31. Date filed (Month, Day, Year)	1 2007 32. Registr			Coan						,	who make "me" #	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Elizabeth Irene Ju1v 2:45p 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carrol1 Westminster 1274 Weller Wav If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 NJ 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 □ vF 215-34-6523 71 24 1936 Director Apr Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at MD Carroll Westminster 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21158 1274 Weller Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 → No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry traumatic event, the Medical Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Trene Elizabeth Frank Ernest H. McLaren 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1274 Weller Way, Westminster, MD 21158 f Health a H. Douglas New (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h permit. Pages Department of I Important: If Its any Injury or o' 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 7-9-07 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paige Haight Herbert P.O.Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Physician years /Medical Due to (or as a consequence of): Examiner Myo cardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? 1 ☐ Yes 2 ☐ ₩6 1□ Yes 2 No sspital or Attending Physician: Thours after death.

Ineral Director: After this certificat filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Paesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28d. Describe how injury occurred 28h Time of Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person wno completed cause of death (Item 23a) (Type, Print) 1380 Zaft rrogress ELdersburg 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** July Gertrude Negin 12:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 9, 1920 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛣 F Months Hours 86 "Ohio 277-16-5058 Yrs. July Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ▼No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ă 3618 Littledale Rd. 20895 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auctioneer Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tant: if Item 27 is marked ott jury or other traumatic even Elias Landskroner Elenore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elliott J. Negin / Son 1545 18th St. NW #712, Washington D.C. 20036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any Injury or once. Chesapeake Crematory 7/10/07 Beltsville, MD 21. Signature of Funeral Service Licenses M00382 22. Name and Address of Facility Rapp Funeral and Cremation Services Julet takunan 933 Gist Ave., Silver Spring, MD 23a. Part1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Physician foreast cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 hes autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: the funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes → No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 1 1

Sullika Schogailer,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Negistrar's Signature

29c. License number

1472 Clery hoest towar 5, her spring

00054566

29d. Date signed (Month, Day, Year)

State

Registrar

2700 Charles St balt nove MD 212/8

Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

2007

Registrar's Signature

Sebecca Commo

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #7, perFH, C869, 7/16/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9 Month Year Physician PELLETREAU 201 JUIN 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Howard County Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7-19-1971 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex **Funeral** Year) Days Min. Months Hours 1 🔀 M 2 🗆 F 35 36 Director 216-66-2782

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar signed by the a been sign has le 2 s certificate ha irector, page this certific ral director, : After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division or Vital Records, P.O. Box 68760,

Usual Residence o	f Decedent											
10a. State Maryland	10b. County Howard		10e. City, Town	or Loca								e City Limits ∕es 2 □ No
Maryland  10e. Street and Nu  4820 Dorse  11. Marital Status  1 ☑ Never Mari	mber				10f. Zip Code				10g. Ci	tizen of What Co	ountry?	
1920 Dona	ey Drive #4				21	042			Uni	ted State	c Ameri	ca
11. Marital Status		12. Was Decedent E	ver in U.S.	13. W	as Decedent of H Yes, specify Cuba		Origin? (Specif	y Yes or No		14. Race - Ame	erican Indian	
1 ☑ Never Mar	ried 2 Married	Armed Forces?	0					can, etc.)		Black, Whi		
3 ☐ Widowed	4 Divorced	If Yes, Give Year or Dates:		11	□Yes 2KINo	Speci	ity:			Specify: "	hite	
(Spe	15. Decedent's Edu cify only highest grad	cation e completed)	16a.	(Give ki	nt's Usual Occup	durina m	nost of working		16b. k	Kind of Business	/Industry	
(Specification (Speci	ondary (0-12)	College (1-4or 5+	-)		o <i>NOT use retired</i> er Worked	1)			N	lever Work	ed	
17. Father's Name	(First, Middle, Last)		•			18. Mo	ther's Name (F	irst, Middle,	, Maidei	n Surname)		
Thomas Pel	lletreau					Joyc	e Wilkin	son				
19a. Informant's N	ame/Relationship (Ty	pe. Print)	19b.	Mailing	Address (Street	and Nun	mber or Rural R	Route Numb	er, City	or Town, State,	Zip Code)	
Joyce Pell	letreau / Mot	her			orsey Driv	e #4	Ellicot	t City	, MD	21042		
20a. Method of Dis	position  ☑Cremation 3 ☐F	Removal from State	20b. Place of cemeter	Disposi y, crema	tion (Name of atory or other plac	ce)	Date	9	20c. L	ocation - City or	Town, State	Э
	S Other (Specify)		Metro C	remat	tory		7/11/20	07	Cat	onsville,	MD	
21. Signature	ureral Service Licens	ee /		22.	Name and Addre	ss of Fa	cility					
1 /10	low El	velle		F'	leck Funer	al Ho	me 7601	Sandy S	Sprin	g Road La		
23a. Part Enter shock, or hea	the disease, or compl art failure. List only o	ications that caused t ne cause on each line	the death. Do n	not enter	the mode of dyir	ig, such	as cardiac or re	espiratory a	rrest,		Approxi Interval	Between
Immediate Cause disease or condition	(Final	SEPTI	ic SHO	OK							Onset a	nd Death
resulting in death)		,	consequence o	,								
Sequentially list co	anditions	J. —————	MONIA									
if any leading to in cause. Enter Under	nmediate erlying	Due to (or as a	conse juence o	of):								
cause. Enter Under Cause (Disease or that initiated event resulting in death)	s i	CIRRL										
rosoning in ocani,		Due to (or as a	consequence of	OT):								
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23b. Was deceder in the past 12	it pregnant	3c. If yes, outcome p	☐ Fetal death		ctopic pregnancy	,			p	23d. Date of de Month	livery Dav	Year
1 ☐ Yes 2 9 ☐ Unknowr	□No	4□Pregnant at t 9□Unknown	ime of death	5∐ (	Other (specify) _						,	
Part II. Other signi	ficant conditions co	ntributing to death but	t not resulting in	the und	erlying cause giv	en in Pa	rt I.	23e. Did t	obacco	use contribute t	o the cause	of death?
	LIC LIVE	-			, , , , , , , , , , , , , , , , , , , ,			10				ÙUnknown
IZENA	L FAILU	RE					1	24a. Was	an	24b. Were a	utopsv findir	ngs available
D	L FAILUI							auto perfo	psy ormed?	prior to death?	completion	of cause of
BONCE	red to medical	4				26 DI	ace of Death (C	1□ Yes		o 1∐Ye:	s 2□No	
25. Was case refe examiner? 1 Yes 2	<u> </u>	lospital:	it 2 ☐ ER/Out	tnatient	3 DOA Oth	er.				6 □Other (Spe		
27. Manner of Dea		28a. Date of Injury	/ 28b. T	ime of	28c. Injur					ary occurred	ecity)	
1 Natural 2 Accident	5 ☐ Pending investigation	(Month, Day	Year) Ir	njury		k? Yes 2						
	6 Could not be determined	28e. Place of injur building, etc.	y - At home, far (Specify)	rm, stree	et, factory, office		28f.	Location (a	Street a wn, Stat	nd Number or R	ural Route I	Number,
4 ☐ Homicide												
29a. Certifier (Check only one)	2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner state	examination and	dor inve	estigation, in my o	ne, date pinion, d	and place, and death occurred	d due to the at the time,	date ar	s) and manner a nd place, and du	s stated. e to the cau	se(s)
29b. Signature and	title of certifier	Khin			29c. Licens	e numbe	er		29d. Da	ate signed (Mon	th, Day, Yea	ır)
•		Vige	n n	NB	D00	436	62		J	uly 912	2007	
	ress of person who co	L. ,										
MILLY	m BoyCE	HOWAN	en Count	A (.	ENERAL	1/0	SPITAL					

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Registrar

State

31. Date filed (Month, Day, Year)

JUL

11

32 Registrar's Signature

Registrar

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<sup>⊲</sup> Physici		1. Decedent's Name (First, Middle, Last)  SUSSE  PUSh		2. Date of Death Month	Day Year <b>7</b>	3. Time of Death 4 25 p
/Medio Examir		4a. Facility Name (If not institution, give street and number)  MANOR CARE TOLAND PARK	4b. City, Town, or Location of Death  BALTIMORE		4c. County of Death  **BALTIM!	
Funeral Director		5. Social Security Number  250-66-2368  G. Sex  1  M 2  F  7. Age (In yrs. last bin  7. Age (In yrs. last bin  67	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp Cour	place (State or Forei ntry) SC
death with the Iwayland ms 23e or 28e-f show	tor	10a. State         10b. County         10c. City, Town           MD         NA         Balt	in or Location		1	0d. Inside City Lim Y□Yes 2□I
or 284	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
ous ariel beam with the marylar el', or Items 23e or 28e-f show Evan in or mart be millied at	by Funeral	2902 Clifton Ave  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	21216  13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto  1  Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)	U . S . A .  14. Race - Americ Black, White,  Specify:	
"natur "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 1	6b. Kind of Business/Ind	
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e d a g	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M	,	
that the should be the state of	2	Robert Caldwell  19a. Informant's Name/Relationship (Type, Print)  19b	VICTORI  Mailing Address (Street and Number or Run	a Saunc		Code)
Department of Health Important: If item 27 I amy injury or other tra		20a. Method of Disposition  X□ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of cemeter	902 Clifton Ave for places of the place of t	Date 2	Oc. Location - City or To	
		23a Part 1. Enter the disease, or complications that caused the death. Do neshock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac			Approximate Interval Between
/Medical	dlcal Examiner	23a Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unit snying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence of th	not enter the mode of dying, such as cardiac culent accident of):  In Sufficiency			Approximate Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ethel D. Parker 4:00 P M 07 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1953 West Lexington Street Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Days 219-26-7516 69 April 30, 1938 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21223 USA 1953 West Lexington Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: SpecifyAfrican American 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sparky's 12 <u>cleaners</u> clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie Milanda Keeling Warner Lee Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4110 Amos Avenue; Baltimore, Maryland 21215 Sharon D. Felder / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 □Removal from State King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 07/13/2007 Randallstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner burial-transit

**Physician** 

/Medical

**Examiner** 

Funeral

Director

r 28a-f shov notified at

iral", or Items 23a or Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any Injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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death with the Maryland

or Attending Physician: The law requires that the death ce ficate be executed Box 68760, P.0. Division or Vital Records, s after death. the To the Hospital of within 24 hours aff To the Funeral D completely filled in

Physician/Medical Examiner Completed by Certification: To Be filled in by

Medical

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

6 ☐ Could not be

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7001 JOHNNY CAKE #102 WINDSORMILL M

State Registrar

DR. EDWARD 31. Date filed (Month, Day, Year) JUL 1 1

29b. Signature and title of certifier

32 egistrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#5, per INF. G883, 9/15/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** July Ernest R. Plante 2007 5 4:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 515—24—8226 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 D F 75 Director 22, 1932 Massachusetts Usual Residence of Decedent death with the Maryland 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f sh must be notified 1 ☐ Yes 2 📉 No Director Maryland| Montgomery Bethesda 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9209 Topeka St. 20817 United States Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify. Completed by Specify 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental Hitant: If item 27 is marked oth Be Charles 0scar Plante Laura Beaudoin ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other trau Marie H. Plante / Wife 9209 Topeka St., Bethesda, MD 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 7/9/07 4 ☐ Donation 5 ☐ Other (Specify) M00382 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Pervice Licenses Rapp Funeral and Cremation 933 Gist Ave., Silver Sprin 23a. Part1. Ent. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death Year 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 21 Nο Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Learner of Jeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Injury Accident 1 □ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani 8600 Old Georgetown rd. Bethesda MD 20814 31. Date filed (Month State 2007 Registrar

DHMH 17 Rev 1/2001

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			For State Registrar	State of Maryla	-		of Health of Deati			giene Reg. No. 20	07	222	51
	Physici	an	Decedent's Name (First, Middle, Las						2. Date of Dea Month	Day	Year	3. Time of Dea	ath
	/Medic Examin	al	Kyle Jaco 4a. Facility Name (If not institution, give		ds	4b. City, To	wn, or Location	n of Death	July	3 200 4c. County	•	00.20	IVI
	Lxamii	CI	Johns Hopkins	Bay view Hed	ical Conte	Bo	utima						
	Funeral		5. Social Security Number 6. Se		s. last birthday) Yrs.	If Under 1 Months I	Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day	(, Year)		place (State or Fo	reign
	Director		Usual Residence of Decedent		U		2		JuneZ	1,2007		yland	
	show	2	Md. Balti		ity, Town or Lo Essex							10d. Inside City L 1 ☐ Yes 2 [	
	28a-f	Funeral Director	10e. Street and Number	more	LSSEX	10f. Zip C	ode	•		10g. Citizen of V	Vhat Cou		*X.
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	ems 2	iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.			Origin? (Spe	cify Yes or No- Rican, etc.)	<del></del>		can Indian,	
9	rs atte	by F.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1□Yes 2√				Specify		hite	
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1	2_		30. Name and address of person who o	completed cause of death (It	em 23a) (Type,	Print)	10	TO 014 -A					4
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	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Registrar's Sig	DE A	mile							

DHMH 17 Rev 1/2001

			For	State of Maryland /	Department of Health and	Mental Hygier	ne,	02255
			Registrar		Certificate of Death	Reg.	No:	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last	Carlo		Month	Day Year	3. Time of Death
	/Medic		Mae Julia	Seare	1 0 T	Duly 5,	4c. County of Death	13,75
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	Funeral		5. Social Security Number 6. Se		pirthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthi	place (State or Foreign
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	pug 🗼		Usual Residence of Decedent  10a, State 10b, County	10c. City. To	wn or Location	,		10d. Inside City Limits
	Aaryk f sho	ō	Md	4 R	(11'			1 Yes 2 □ No
	28a-	Director	10e. Street and Number	1 10	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	h with	I I	3000 TOWA	nda Ave	113 21215		1151	7
	ems (	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland that Hyglene. So of 28e-f show od other than "natural, or items 23e or 28e-f show event, the Medical Evanithar must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:		Specify: D	a a V
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altimore,			21. Signature of Funeral Service Licens		22. Name and Address of Facility	-007	I DA	crie, min.
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2	(		30. Name and address of person who o	_		5510-5-		1127
		t o	ALU UMA L. 31. Date filed (Month, Day, Year)	32. Registrar's Signature	CENTER DRIVE REI	N FRED DAV	J / 1 VO 2	-1136
	Sta Registi			32. Rigistrar's Signature	" porti			

		1	State of Maryland / Department	ent of Health and Nate of Death	Mental Hygien Reg. N	7111/ 99956
*	6	×	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
47	Physicia		Renp Stewart			ay Year 10.12 AM
A Comment	/Medic Examin			City, Town, or Location of Death		c. County of Death
	_ ∧allilli	ÇI	Mercy Medical Center	Baltimore		Baltimore City
1917	Funeral		5. Social Security Number 6. Sex	nder 1 Year   If Under 24 Hrs. ths Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
au	Director		164-24-7155 1□ M 2 XF 75 Yrs. Mon	Dayo Hours IIIII	Sept. 26, 1	931   Illinois
	pu ,	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	aryla shov	.	Maryland Baltimore Baltimore			1 ∐Yes 2 XXNo
	he M 28a-f otifie	당 L		. Zip Code	10a. C	Citizen of What Country?
	with t	吉	6806 Bellona Ave.	21212		United States
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show yet, the Medical Examiner must be notified at	6	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was D	ecedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
	ter d	ᇤ	Armed Forces? If Yes,  1 1 Never Married 2 Married 1  Yes 2 No	specity Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
336	urs af al", or Exam	by	If Yes, Give 1 ☐ Ye 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	es 2X No Specify:		Specify: white
Maryland 21215-0036	2 hor	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind o	Usual Occupation f work done during most of wor		Kind of Business/Industry
215	thin 7 e. an "r Med	nple	Elementary/Secondary (0-12) College (1-4or 5+)	OT use retired)		
2	ed wi	Sol		st Formation	ne (First, Middle, Maide	eligious Education
D L	tal H d oth even	Be	17. Father's Name (First, Middle, Last)			
<u>Xa</u>	ould Men arke	ျှ	James Aloysius Stewart	Iress (Street and Number or Ru	ristine St	
Jar	2 sh n and is m raum	7	Total Morniague Victimes Victimes (1972)	,		21204
a)	t and Health		20b. Place of Disposition	(Name of		Location - City or Town, State
٥	ages nt of l		1 X Burial 2 □ Cremation 3 □ Removal from State	or other place)	- 0 2007 B	This was Mauriand
Baltimore,	it. Partmen	- 1				altimore, Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amount in Jury or other traumatic event, the Medical Examiner must be notified at once.	<i>y</i> - 8	Dogu O. Mitchell	e and Address of Facility Mitchell-Wiede 6500 York Rd.	feld Funera Baltimore	al Home, Inc. e, MD 21212
2			23a. Pent . Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician	6 1	Immediate Cause (Final disease or condition	Multiforn	e	7 weeks
	/Medical Examiner		Due to (or as a consequence of):	11		
- 184.	LAdillilei	_	Sequentially list conditions, Due to (or as a consequence of):			
	ed sit	nine	Cause. Enter Underlying Cause (Disease or injury that initiated events Cause initiated events Cause (Disease or injury that injury that injury			
	xecut and al-trar	Examiner	that initiated events c			
8760,	cate be executed physician and the burial-transit	dical E	d			
687	ficate p phys	gi	0.			
Box	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	-i- nreangnov		23d. Date of delivery
m	death e atte d for	icia	in the past 12 months?  4 Pregnant at time of death  5 Other	pic pregnancy er <i>(specify)</i>		Month Day Year
O.	that the de led by the a detached	hys	9 Unknown			
ď.	ss tha	by P	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.		co use contribute to the cause of death?
ğ	w requires to been signer should be	pa			1 ☐ Yes	No 3 Probably 4 Unknown
ecc	has be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>		No.			performed 1□ Yes 2	? death? No 1 □ Yes 2 □ No
or Vital Records,	sician: The la certificate ha irector, page 2	Be (	25. Was case referred to medical examiner?		ath Check onl one	
7	S .S . ₹	ဥ	No Hospital 1   Inpatient 2   ER/Outpatient 3		Home 5 ☐ Residence	
Ę.	ffel The The	on:	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? I 1 ☐ Yes 2 ☐ No	Zod. Describe now ii	ijury occurred
Sic	Attending r death. ector: After by the fune	cat	3 Suicide 6 Could not be 28e Place of injury. At home farm street for		28f. Location (Street	t and Number or Rural Route Number,
Division	or A after of Direct in by	Certification:	4 Homicide determined building, etc. (Specify)	,,	City or Town, St	ate)
-	Hospital or the hours afte Funeral Direction Interest of the tell filled in It		29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	gation, in my opinion, death occ	curred at the time, date	and place, and due to the cause(s)
	To the I within 2.	Me	29b. Signature and title of certifier	29c, License number	29d.	Date signed (Month, Day, Year)
	_		Jan M. Colle MD	D 63112	Ju	145 2007
,	37		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	. ( 1 -	1 0	A Ball
/			31. Date filed (Month, Day, Year) 2007 82. Registrar's Signature	1 Center 30	1 st. 1/av	place, Balkmore MD 2120,
	St Regist	ate	31. Date filed (1901), Day, Year) 2007	,		2120
	negisi	reit				

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

with the Maryland

72 hours after death

8

The law requires that the death certificate be executed

Division of Vital Records, P.O.

or Attending

2

rland 21215-0036

32. Régistrar's Signature

			1 - For State Registrar		of Maryland		artmen rtificat			and M		Reg. No.	007	22250
	Physici /Media		1. Decedent's Name (First, Middle,	She000	nd.						2. Date of Dea Month	Day Day	Year O 7	3. Time of Death
ز	Examir		4a. Facility Name (If not institution,				4b. City,	Town, or	Location o	of Death			inty of Death	
		Ш	Genesis Long						imore				NA	
	Funeral Director		5. Social Security Number  248–62–2353  Usual Residence of Decedent	6. Sex 1	7. Age (In yrs. Ia	Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Birt (Month, Da 3-2-1	h y, Year) 932	9. Birth Cou	place (State or Foreign ntry) S.C.
	yland now		10a. State 10b. County		10c. City,	, Town or Lo	ocation							10d. Inside City Limits
	a-f-e	cto	Md. NA			Ba	ltimo	re						1 Yes 2 □ No
	or 28	Dire	10e. Street and Number				10f. Zip					_	of What Cou	ntry?
	• 23a	rai	1107 Darley A					2121					JSA	
5-0036	within 72 hours after deeth with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow In Marigal Examiter treat be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F	2 No		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, ecify: B.	
7	ithin 72 ho ne. nen "natur nedical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)			(Give	dent's Usua kind of wo DO NOT us	rk done a	lurina mosi	t of worki	ng	16b. Kind o	f Business/Ir	ndustry
2	filed w Hygier other th	S	12th grade			Rec	iever						Food	S
yland	Mentel	To Be	17. Father's Name (First, Middle, L Charlie		Sheppa					Nora		Tay	ylor	
Mary	2 4 - 9	l ii	19a. Informant's Name/Relationsh Jeanette Sheppa		Wife						<i>i Route Numbe</i> timore,		wn, State, Zi, 21218	o Code)
	s 1 and Health tem 27 other to		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nan	ne of	1		ate		on - City or T	own, State
Itimore,	@ ° = %		1 Substitute 1 Section 1 Substitute 1 Section 2 Section		State	<sub>metery, crei</sub> rison	-		· 1	7–10	07			ls, Md.
≣	permit. Peg Depertment Importent: I eny Injury o		21. Signature of Funeral Service L		Gal		2. Name an				arch F.			15, M.
ñ	88 8 8		Draft Met	lar			1101	E. N	orth	Ave.	, Balti	more,	Md.	21202
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to	oach line.	elih ence of):	s of the	B	leg	with	infecte	d had	nwe	Approximate Interval Between Onset and Death
3/60, 8/	ate be executed hysicien and he burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque	ence of):	hear	t c	Hice	nl en 4	1			
O. Box 6	death certific e attending pl d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregnan birth 2  Fetal ( nant at time of dea lown	death 3□	Ectopic pr		00			23d.	Date of deliv Month	ery Day Year
ecords, P	The law requires thet the de ite hes been signed by the a rage 2 should be detached	by	Part II. Other significant condition	Pa ( e	leath but not resul	lting in the u	nderlying c	ause give	n in Part I.			bacco use d		the cause of death?
ဝ္ပ	2 5 0	Completed	U .								24a. Was		tb. Were auto	opsy findings available ompletion of cause of
ב		Com									perfo	med3/	death? 1 ☐ Yes	
VITAI	siclan: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?							e Death	(Check only o	ne)		
6	9 w =	2	1 ☐ Yes 2 ☑ No  27. Manper of Death			P/Outpatier			4 ☑ Nu		ne 5 Resid			fy)
	on After	tion	1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at :? ∕es 2 ∐ l		28d. Describe l	iow injury oc	curred	
DIVISION	To the Hospital or Attending within 24 hours effer death.  To the Funerel Director; Affer completely filled in by the fune.	Certification:	2 Accident investigation of Could not determine the co	ot be 28e. Place	e of Injury - At hon ling, etc. (Specify)	ne, farm, str					28f. Location (5 City or Tox		umber or Rur	al Route Number,
)	he Hospita n 24 hours he Funere	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the tand man	e best of my know pasis of examination or stated.	rledge, deati on and/or in	h occurred vestigation,	at the tim	e, date and pinion, dea	d place, a	and due to the	cause(s) and date and pla	manner as s ce, and due t	stated. to the cause(s)
	To t To t	Σ	29b. Signature and vitle of certifier	1115					number	00		29d. Date si	gned (Month,	Day, Year)
			· What	2 Mi	)			000	6471	88			17/0	
	4		30. Name and address of person w	10	1600 1	N. N		04/	AL F	\UE	BAUII	MORE	MD	4217
	Sta Registr	_	31. Date filed (Month, Day, Year)	1 2007	Registrar's Signatu	TLO TLO	Anne &							

DHMH 17 Rev 1/2001

#### 07-05013 G

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1.	For State	Cen	tificate of	Death			Reg. I	No.	1 17 17	T OCOF	
	Re	gistrar Decedent's Name (First, Middle,Last)		inicate of	Dodar	-		te of Death	£.,	. U	3. Time of Death	
Physician/ Examiner		Gerard Smith					Mo Jul	nth y 1, 2007	·	ear	0728 hrs	
		a. Facility Name (if not institution, give st	reet and number)	1	4b. City, Town, or	Location of E	Death		4c. County	of Deatl	h .	
		4800 block Herring Run Drive			Baltimore	Train	- 10 B	ate of Birth(I	W 1/DD 200	√\ 0 Bi	rthplace (State or	
Funeral	5.	Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yea  Months Day		Min. 8. D	ate of bitti(I	MIM/DD/TT1	Forei		
Director		220-98-1494 1x M	2F	25 Yrs	S		Ji	me 13,	1982		MD MD	
8:		sual Residence of Decedent  0a. State 10b. County	10c. City,	Town or Locat	tion						10d. Inside City Limits	
ow any	1	MD			Balti	imore					1 X Yes 2 No	
Maryland 28a-f show d n oner	3 1	0e. Street and Number			10f. Zip Code			10g	Citizen of \	What Co.	untry?	
the Maryland a or 28a-f sh tified at one Director		3056 Stafford Street				21223				USA		
h with the Maryland ems 23a or 28a-f sho Le mailfed at once. leral Director			2. Was Decedent Ever in U.	.S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin	? (Specify	Yes or No-		ce - Ame nite, etc.	rican Indian, Black,	
r death with , or items 23 r must tem		1 X Never Married 2 Married	Armed Forces?  Yes 2 X No				de to raour	, 0.0.,	1		n American	
safter of rall', or	<b>&gt;</b>	3 Widowed 4 Divorced If	Dates:	1_	Yes 2 X No		and and considered	one II	6b. Kind of			
natura Exami		15. Decedent's Education (Specify only		16a. Decede during r	nt's Usual Occupa most of working life	e. DO NOT us	se retired)	one '	OD. MING OF	Dusinos	, mada y	
S6 In 72 h In man "1		Elementary/Secondary (0-12)	College (1-4 or 5+)		clerk			l	foo	d cor	m	
5-0036 ed within 72 hours lygiene. other than "natur the Medical Exam Completed		7. Father's Name (First, Middle, Last)			CIEIN	18.Mother's	Name (Firs	t, Middle, Ma	iden Surna	me)	γ	
21215-0036 Juld be filed within 72 In Mental Hygiene, In marked other than ic event, the Medical			E. Smith, Sr.				M	argare <u>t</u>	A. Whi	te		
212 ould b d Men d Men ic eve	οГ	9a. Informant's Name/Relationship (Typ			ng Address (Stre							
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of freath and Mental Hygiene. The first in an arked other than "natural", or items 23a or 28a-f she and items 7 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examinar must be netified at one to the results of the Commission of the Netical Examinar must be netified at the context of the Commission of the Comm	L	Charntae Douglas / S			3056 Staffo		et; Ba	ltimore	Mary I 20c. Locatio	and on - City o	21223 or Town, State	
re, s l an of Hea If iter	1	20a. Method of Disposition  1 X Bunal 2 Cremation 3	Removal from State	crematory or o	other place)							
Page Page nent c		4 Donation 5 Other Specify:	Mc	ount Zion	Name and Addre		07/12/				Maryland	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If litem 27 is marked other than injury or other traumatic event, the Medic.		21. Signature of Funeral Service License		22.	638 N.Gilr		-	ie Fune:		-	21217	
	+	23a. Part I. Enter the disease, or emplic	ations that caused the death	h. Do not enter	the mode of dying	g, such as ca	rdiac or resp	piratory arres	st, shock, or	heart	Approximate Interval Between Onset and	
ysician	- 1	failure. List only one cause on each	n line. Iultiple Gunshot Woul								Death	
Examiner			ue to (or as a consequence									
H.	.	Sequentially list conditions, b	uentially list conditions,									
	<u>=</u>	cause. Enter Underlying Cause										
	xam	(Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence	of):								
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed retent. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Medical Examiner	d										
s0, te be ex nysician s burial	影	UNPENDED	AMENDED				_		23d. Dat	e of deliv	verv	
376 ficate g phy s the t	Ž,	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		Fetal death	3 Ectopic	pregnancy		Mon		Day Year	
x 68 h cert tendin use a	sician/I	past 12 months?	4 Pregnant at time of o	teath 5	Other (Specify)				1			
, P.O. Box 6876 rres that the death certifical signed by the attending phe be deached for use as the	>1	1 Yes 2 No 9 Unknown  Part II. Other significant conditions	9 Unknown	reculting in the	e underlying caus	e given in Pa	rt I.	23e. Did to	bacco use o	ontribute	to the cause of death?	
b.O. that the red by detach	집	Part II. Other significant conditions	contributing to death but not	resulting in the	e andenying code	o g		1 Yes	2 🗸 No	3 F	Probably 4 Unknown	
S, F nuires en sige	E G							24a. Was a			e autopsy findings available	
ord aw rec	ompleted							autops	med?	death		
Rec The I	5				26 DI	ace of Death	(Check only	1 Yes	ZNO	1 🗸	res 2 140	
Vital Records, system: The law requirence in the certificate has been secretificate  by the secretificate has been secretificated by the secretificate has been secretificated by the secretificate has been secretificated by the secr	B	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatie		Other;			Residence	6 🗸 0	ther: Scene	
of Vital Rec	의	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time		njury at Work	? 28	d. Describe h	now injury o	ccurred		
nding th. :: Aft	Ë	1 Natural 5 Pending	FOUND: Jul 1, 2007	FOUND: 0722 hrs	1 1	Yes 2 🗸	NO	bject sho				
Division tal or Attendi rs after death. al Director:  led in by the fi	licat	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At		treet, factory, offic	e building, et		or Tours S	tata)		r Rural Route Number, City	
Divis nspital or A hours after nneral Dire	Certification:	4 V Homicide determined	(Specify) Local Str					00 block He	erring Run		Baltimore, MD	
Ho Fu	cal C	29a, Certifier	an: To the best of my knowled On the basis of examination	edge, death oc	courred at the time	, date and pla	ace, and du	e to the caus e time, date	e(s) and ma and place.	anner as and due t	stated. to the cause(s)	
To the comple	ᅙ	10 1	and manner stated.	n and/or investi		ense number					(Month, Day, Year)	
	Σ	29b. Signature and title of certifier	////			C.M.E.			July 2,			
5		XIM	XVI									
1		30. Name and address of person who of Susan Hogan MD. Assis	ampleted cause of death (Its tant Medical Examin	em 23a) er 111 P	enn Street, B	altimore,	MD 2120	1				
\	ate		22 Pogietrarie Sign									
State Registrar 31. Date filed (Month) Day Year 2007												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** STEVENS 4:30 A IRENE TUL 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BACTIMORE TOWSON CARE RUXTUN MANOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 63 yrs Funeral 6. Sex Months Days Hours 1 □ M 2 0 F 1070271943 MD 219-40-7091 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23e or 28a-f show nust be notified at 1 ☐ Yes 2 🕱 No **Funeral Director** MD Essex Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f Zip Code death with 21221 USA 1 Brett Ct. Apt. 302 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. the Medical Examiner filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: Specify: White Completed by Year or Dates: 3 Wildowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hoffman Bus Company Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other then ury or other treumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Erna Langehan Albert Kreuzmann 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Timothy Stevens/Son 12 Strassburg Circle Shrewsbury, PA 17361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Jul 10 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Beltsville, Maryland Chesapeake Crematory Inc. 2007 ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaturi of Funeral Service Licenses 22 Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG Physician CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Oue to (or as a consequence of) Box 68760, physician the IF FEMALE 9SF 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ö in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No certificate 2 -No Division of Vital Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: , d in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2001 D57722 MD

State Registrar 1838 GREENE TREE PUAD #300 PIKESVILLE MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Angistrar's Signature

LEONARD RICHARDSON M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sayko Arpad James 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 X M 2 □ F 95 Hours 123-05-1024 Director 30,1912 April Hungary Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director Prince George's 1 ☐ Yes 2 XNo Maryland Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7411 Varnum St. 20784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Yes 2 🗓 No White þ Specify: 3 Widowed 4 Divorced filed within 72 hours Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mer tal Hygiene. Important: if item 27 is marked other than " any Injury or other traumatic event, the Meg once. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Space Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Szajko Zsofia Tavik Laszlo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7411 Varnum Rd., Hayattsville, MD Edit Maria Sayko / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 7/9/07 Beltsville, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 21. Signature of Fungral-Service Licer M00382 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 ☐Unknown as been signal Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed: Yes 2 No certificate ha 2 No 1□ Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 √No ဥ 1 Impatient 2 ER/Outpatient 3□ DOA After this 27. Manne / Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) 1 V atural Injury 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff

To the Funeral D

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Suite 210 Lanham MD 2070 F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** A M July Janet Kathleen Tavenier 8 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 18920 Earhart Ct Gaithersburg Montgomen If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 € F 53 264-11-2114 Florida JULY 25, 1953 Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 es 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA Earhart 20879 18920 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Manager 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecil Garner Florence Detrek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C+, Debra Shank / HCPOA 18920 Earhart Gaithersburg MD 20879 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐ Other (Specify) Anatomy Gifts Registry July 8,2007 Hanover, MD 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee > 60 7522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CELL LUNG METATIATIC IMMIL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy performe 1∐ Yes 25No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 🔲 Yes 27 No 2 ER/Outpatient 3 DOA မှ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification:

Examiner be executed burial-trar P.O. Box 68760, physician the attending p the signed by t d be detach Division or Vital Records, been sign cate has l page 2 s certificate I After this funeral

the Hospital or Attending

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Funeral** 

Director

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"natural", or items

th and Mental Hygiene.

7 is marked other than "natul traumatic event, the Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once.

**Physician** 

/Medical

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1.XNatural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) and manner stated. 29b. Signature and

29c. License number D 35 635

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Kurch, mo Day,

18111 32 Registrar's Signature PLI: P Da. OLNE

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** DORIS 47166 1021 VER 09, JULY 03:35# 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Days 1 □ M 2 □ F 540148 66 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. inside City Limits Bolhnon 1 kes 2 No Directo MANGIANO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/2/3 USB 515 Funeral Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 217 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First: Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BEAKE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMERE A 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation Stother (Specify) Enform Br 21. Signature of Scheral Service Ligenses Re TENSTON Enter the disease, or heart failure. L e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Îmmediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical **Examiner** ADULT RESPIRATORY DISTRESS SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran SEPSIS Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛱 No Month Day Year 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEGENERATIVE SPINE DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed BREAST CANCER 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No s certificate has birector, page 2 s autopsy To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2

Oate of injury
(Month, Day Year) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 🗷 Natural 5 Pending investigation in 24 hours are.
the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated. Medical 29a. Certifier within 24 ho

To the Fune 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46356

State Registrar KHASROW

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

OSLER

DRIVE

TOWSON.

MARYLAND

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

M.D.

32. Registrar's Signature

7601

TABASSI

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryiand		tificate of			Reg. No.	07	2226
ı	Physici		1. Decedent's Name (First, Middle, Las Charles	st) Edward		Turner			2. Date of I Month June		oď <sup>ear</sup>	3. Time of Death  2:26 p <sup>M</sup>
N. A.	/Medio		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	or Location of D	eath	4c. County	of Death	2.20 p
	,		Prince Georges Commun				Cheverly	T 1511-1-04	Um la man		e Geor	
l.	Funeral Director		411-48-7702	<b>9</b> 7 № 0 □ □	(In yrs. las	st birthday) _ Yrs.	Months Days		Min. 8. Date of E (Month, I April	Day, Year) 10, 1930	_Coun	lace (State or Foreign try) nessee
	land ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	a-f sh	ctor	Maryland Prince Ge	eorges		Laur	el					1 ☐ Yes 2 ☐ No
	or 28 be no	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Coun	try?
	eath v	Funeral	1001 Turney Avenue	12. Was Decedent E	ver in IIS	13 W		)707 Hispanic Origin	? (Specify Yes or I	United St	ates A	
ယ	after d or iten niner	Fun	1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No		54			? (Specify Yes or I Puerto Rican, etc.)		ck, White,	
Ö	ural", c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			☐ Yes 2 No			Specify		Black
<u>7</u>	in 72 h "nati ledica	olete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give k	ent's Usual Occu kind of work done O NOT use retire	during most of	working	16b. Kind of B	usiness/Inc	dustry
212	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+ 5+	-)	Grain	Inspector			Departme	ent of	Agriculture
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last,		***		unk		Name (First, Midd th Turner	lle, Maiden Surnan	ne)	
2	should and Men s marke umatic	ပ	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailine				nber, City or Town,	State. Zio	Code)
<u>≅</u>	and 2 sealth ar n 27 is		Faye Turner / Wife	,			urney Aver					,
ore,	es 1 an of Heal fitem 2 rother		20a. Method of Disposition 1, ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ce of Dispos netery, crem	ition (Name of natory or other pla	ice)	Date	20c. Location -	City or To	wn, State
<u><u>Ĕ</u></u>	. Pages tment of I tant: If Ite		4 Donation 5 Other (Specif	v)	Ivy H	ill Cem			/6/2007	Laurel,	Maryla	ınd
Ba	permit. Departr Importa any inj		21. Signature of Fun ral Service Licer	vell.		100	Name and Address		601 Sandy S	Spring Road	llaure	el, MD 20707
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		the death.						Laure	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a ACUTE MYO								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):						
38	Examine	je je	Sequentially list conditions,	b. ATRIAL FIE								
<b>&gt;</b> .	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CHRONIC OF			LMONARY DI	SEASE				
Ö,	e exec ian an	Еха	resulting in death) Last	Due to (or as a			TODY FALLS	IDE				
68760,	ificate be executed g physician and as the burial-transit	edical		d.	3DEINT 1	INLOI THA	TORT TATES				-	
Box 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p						23d. Da	ite of delive	ery
о. В	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	by Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 2 4□Pregnant at t 9□Unknown			Ectopic pregnand Other (specify) _	<u> </u>		- Mc	onth	Day Year
<u>Ч</u>	w requires that the de been signed by the should be detached	, Phy	Part II. Other significant conditions of	ontributing to death but	t not result	ing in the un	derlying cause gi	ven in Part I.	23e. Di	d tobacco use conf	tribute to th	ne cause of death?
Records, P.	quires n sign	d by							1 (	X Yes 2 □ No	3 ☐ Prob	ably 4 Unknown
၀၀	law rei as bee 2 shot	Completed							24a. W		Were auto	psy findings available mpletion of cause of
Ě	The lavate has	Som							pe 1⊡ Yes	rformed?	death?	2□ No
Vital	ictan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			l Ot	hor	Death (Check onl			
	Phys r this ral dir	- T	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatien		R/Outpatient 28b. Time of	3 DOX		<del> </del>	esidence 6 Oth		y)
on	nding th. r: Afte e fune	ation	1 ☐ Natural 5 ☐ Pending investigation	(Month, Day	Year)	Injury	28c. Inju Wo M 1	rk? ]Yes 2∐No				
Division or	I or Attending Physician: The I after death.  Director: After this certificate ha lin by the funeral director, page.	Certification:	3 Suicide 6 Could not be determined	28e. Place of injurbuilding, etc.	y - At hom (Specify)	ne, farm, stre	et, factory, office			(Street and Numb Fown, State)	ber or Rura	l Route Number,
1	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it		(Check only 2 Medical Exal	ysician: To the best o								
	thin 24	Medical	one)  29b. Signature and title of certifier_	and manner stat	ed.		29c. Licen	se number		29d. Date signe	ed (Month.	Dav. Year)
	F 3 F 8		Valle	Pin	-		72	757	77	6/2	0/0	77
,			30. Name and address of person who	completed cause of de	ath (Item 2	23a) (Type, F		-	/	-/3	/	/
	8			01 Hospital D			MD 20785					
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	rs Signatu	ire	A					
DH	MH 17 Rev 1/2		JUL 1 1 200	Shin	J.	Spense						
						ORI	GINAL					

# 1. Decedent's Name (First, Middle, Last) **Physician** Tanlor Kevin /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at annea. Be Completed by Funeral Director Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - For State Registrar

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4a. Facility Name (1		give street and no			4b. City,		Location of Death	1.48	. 4	c. Count	y of Deat		
5. Social Security N 219-76		6. Sex 1 □ 🙀 2 □ F	7. Age (In yrs. Id	. Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	nth ay, Yea 1, 19		9. Birt Co	hplace (Si untry) <b>Mary</b> l	ate or Foreign
Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	ocation							10d Insi	de City Limits
Maryland	Tob. County	N/A	100. 019	, TOWN OF EC	Soution	е	Baltimore						Xes 2 □ No
10e. Street and Nur	mber				10f. Zip	Code			10g. C	itizen of	What Co	untry?	
1593 Ingl	eside Ave	nue					21207					S.A.	
11. Marital Status		Armed F		S.   13.	Was Deced If Yes, spec	ent of Histify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No o Rican, etc.)	D-		ce - Ame ck, White	rican India e, etc.	ın,
1 ☐ Never Marr 3 ☐ Widowed		ed 1 Yes If Yes, 0 Year or	Datee:	982 986	1□Yes 2	<b>≥□ ½</b> ∘	Specify:			Speci	fy:	Black	•
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Elementary/Seco		<del></del>	(1-4or 5+)	life.	DO NOT us	e retired,	Counselor	ung		S	tate O	f Maryl	and
17. Father's Name		 Las <i>t</i> )				Diag	18. Mother's Nam	ne (First, Middle	, Maide	en Surna	me)		
		bert T. Taylo	r							e Jon			
19a. Informant's Na	ame/Relationsl	nip (Type. Print)		19b. Maili	ng Address	(Street a	and Number or Ru	ral Route Numb	er, Cify	or Town	, State, 2	Zip Code)	
Joyce Ta	ylor Moth	er			1593 lng	gleside	Avenue Bal	timore, Ma	rylan	d 212	07		
20a. Method of Disp		3 ☐ Removal from	C	lace of Dispo emetery, cre	osition (Nam matory or o	ne of ther place	e)	Date	20c.	Location	- City or	Town, Sta	te
4 □ Donation	5 ☐ Other (S	pecify)					s Cemetery	07/12/07	•	С	wings	Mills, N	/ld.
21. Signature of Fu	ineral Service	Licensee	John	2	2. Name and	step E	s of Facility Brothers Fun utaw Place I	eral Servic	e, P.	A. 1217			
23a. Part1. Enter t	he disease, or	complications that	caused the death	. Do not en	ter the mode	e of dying	g, such as cardiac	or respiratory a	arrest,	14-11		Approx	rimate I Between
Immediate Cause ( disease or condition resulting in death)		a	lyocard	ial .	Inf.	nt	in	·-				Zo	and Death
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) i	errying injury	b Due to	o (or as a consequ	ience of):	U								
resulting in death) i	Lust	d	o (or as a consequ	ience of):									
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? ☐ No	1 □ Live	utcome pf pregna birth 2  Fetal gnant at time of de nown	death 3	⊒Ectopic pro ⊒ Other (sp						ate of del	ivery Day	Year
Part II. <b>Other signi</b>	ficant condition	ons contributing to	death but not resu	ilting in the u	inderlying ca	ause give	en in Part I.	23e. Did		use cor	ntribute to		e of death?
								24a. Was auto perfe 1  Yes	psy ormed?	24b	. Were au prior to death?	completion	ings available of cause of
25. Was case refer	red to medical						26. Place of Dea		-4		163		
examiner? 1 ☐ Yes	No	Hospital:	inpatient 2 1	ER/Outpatie	nt 3□ DO	A Othe	er: 4 🗆 Nursing H	ome 5□Res	idence	6 🗆 🔿	her (Spe	cify)	
27. Manner of Deat Natural 2 Accident	h 5 🗌 Pendin investig	q (Mo	e of Injury onth, Day Year)	28b. Time of Injury	of 2	8c. Injury Work 1 🔲 \	/ at i? Yes 2 □ No	28d. Describe	how in	jury occu	rred		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ned   20e. Flat	ce of injury - At ho ding, etc. (Specify	me, farm, st	reet, factory	, office		28f. Location ( City or To	Street www. Sta	and Num	ber or Ru	ural Route	Number,
29a. Certifier (Check only one)		g Physician: To the Examiner: On the and ma											use(s)
29b. Signature and	title of certifie	$\bigcap$				. License			29d. E	ate sign	ed (Mont	h, Day, Ye	ar)
· A	u ()	00				Es -	- 000		J,	1	5, 1	2007	
30. Name and addr	ehrer	who completed car	Vorth W	23a) (Type,	Print)	f p	oaltimo	ie, Ma	ale	ind	2	128	7
31. Date filed (Mon	th, Day, Year)	007 15	Registrar's Signal	ture	A. 18			•	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death

2. Date of Death

Registrar DHMH 17 Rev 1/2001

10 State

Medical Certification: To

Division or Vital Records, P.O. Box 68760,

llison Grace Te		Otato of Maryland / Box	oartment c	of Health and Mentai	_	ibie.	17 0500
Dhusisia		Registrar  1. Decedent's Name (First, Middle,Last)	ertificate c	of Death	2. Date of Death	g. No.	3. Time of Death
Physicia Medical Exami		Allison Grace Tede	schi		Month July 8, 200		0930 hrs
		4a. Facility Name (if not institution, give street and number)  Carroll Hospital Center		4b. City, Town, or Location of Dea Westminster		4c. County of Deat	h
Funeral			s. last birthday)	If Under 1 Year If Under 24H	rs. 8. Date of Birth	h(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		219-77-6332	Yr	Months Days Hours N	fin.	Forei	
any	,=	Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ity, Town or Loca				10d. Inside City Limits
<b>*</b> .	ř	MD Carroll	ty, Town or Loca	Sykesville			1 Yes 2 No
0036 within 72 hours after death with the Maryland jene. her than "natural", or items 23a or 28a-f show Medical Examiner must be notified at once.	Director	10e. Street and Number		, 10f. Zip Code	10	g. Citizen of What Cou	
ith the		7654 Swallow Road  11. Marital Status   12. Was Decedent Ever in	IIS 13 W	21784 Vas Decedent of Hispanic Origin? (	Specify Ves or No-	USA	rican Indian, Black,
eath w items	Funeral	1 v Never Married 2 Married Armed Forces?	If	Yes, specify Cuban, Mexican, Pue		White, etc.	noan moian, black,
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1_	Yes 2 X No specify:	100	Specify: W	nite
hours natur Exam	ed t	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupation (Give kind omost of working life. DO NOT use i		16b. Kind of Business	/Industry
5-0036 ited within 72 Hygiene. I other than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) N/A		N/A	20.0	N/A	
21215-0036 ould be filed within 7 Mental Hygiene. i marked other than ic event, the Medica	Con	17. Father's Name (First, Middle, Last)			me (First, Middle, M	laiden Surname)	-
21 be f rkec	Be	Steven F. Tedeschi				Kogut	
nore, MD 21215- ages I and 2 should be filed and of Health and Menial Hyg It: If item 27 is marked out other traumafic event, the	T <sub>0</sub>	19a. Informant's Name/Relationship (Type, Print) (Parent: Mr. & Mrs. Steven Tedeschi	3) 19b. Mailir	ng Address (Street and Number of Swallow Road S			
e, MD ; l and 2 shou Health and l item 27 is r traumatic		20a. Method of Disposition 201	b. Place of Dispo	osition (Name of cemetery,	Date	20c. Location - City o	
Baltimore, permit. Pages I al Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State	crematory or cresley Fi	reedom Cemetery	7/12/07	Sykesvill	le. MD
Baltim permit. Pa Departmen Important injury or o		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		AIGHT AFUNERALITY HO			
		23a. Part I. Enter the disease, or complications that caused the dea	S	ykesville, MD 21	784 (410	))-795-1400	)
Physician /Medical		failure. List only one cause on each line.					Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)  a. As h via C III Lic		amomalous right coro	nary artery		Death
		Sequentially list conditions, b.					
	ine	if any, leading to immediate cause. Enter Underlying Cause  (Disease or injury that initiated cause)	e of):				
led nsit	Examine	events resulting in death) Last Due to (or as a consequence	e of):				
ox 68760, eath certificate be executed attending physician and for use as the burial - transi	dical	d.  X UNPENDED AMENDED 200 6	ME _ O	70 9/0/07 177			
760, cate be physici he buri	Med	#Z3a,Z/,Z0a-I,  IF FEMALE: 23c. If yes, outcome of pr	penyle,go egnancy	70 <b>,</b> 8/9/0/ 11		23d. Date of delive	ry
687 certificanding	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of	donth	Fetal death 3 Ectopic pres	gnancy	Month	Day Year
Box 68760, e death certificate b the attending physical for use as the burner of the b	Physician/Me	1 Yes 2 No 9 Unknown g Unknown	5 (	Other (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	by PI	Part II. Other significant conditions contributing to death but no	t resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds, I	ted				24a. Was a		utopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  **I Director: After this certificate has been sted in by the funeral director, page 2 should!	Completed				autops	med? death?	completion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical		26.Place of Death (Che	1 Yes 2	2 No 1 V	es 2 No
Vita nysicia this ce	o Be	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 🗸 DOA Other Nu	sing Home 5 I	Residence 6 Other	er:
n of Vi ling Physi After this funeral dir	[i	27. Manner of Death  1 Natural 5 Pandian (Month, Day, Year)	28b. Time of		. 28d. Describe h	ow injury occurred	
Sior Attend r death ector: by the	catio	2 X Accident Investigation Fnd 7/8/2007		1 Yes 2 X No eet, factory, office building, etc.		asphyxiated	ural Pouto Number City
Divis pital or At ours after d ours after d filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) resid		eet, factory, office building, etc.	7654 Swa	ate) I Low Road Syk	ural Route Number, City
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowl	edge, death occi		ind due to the cause	e(s) and manner as sta	ted.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner; On the basis of examination and manner stated.	n and/or investig		d at the time, date a		
	Σ	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mi	onth, Day, Year)
		30. Name and address of person who completed cause of death (It	em 239)	O.O.IVI.E.		July 9, 2007	
N		Patricia Aronica-Pollak MD. Assistant Medica		111 Penn Street, Baltim	ore, MD 21201		
		31. Date filed (Month, Day, Year) 32. Redistrar's Sign	ature	1			
Regist	ucil	111 1 1 2007   Maria	11. 12	1847 /			

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aret Anna Tanzey	State of Maryland / Department of Health and Mental Hygie

Margaret Anna Tanzo	ey State - For State	of Maryland / Dep	ertificate of		d Mental Hy	ygiene Reg.	No.	
Physician/	Registrar 1. Decedent's Name (First, Middle,Las					2. Date of Death	ay Year	3. Time of Death
Medical Examiner		nna Tanze	У		Location of Death	July 6, 2007	4c. County of Deat	0801 hrs
	4a. Facility Name (if not institution, giver Jerusalem Road seuth of	e street and number)	7.	Kingsville	Location of Death		Baltimore Co	
Funeral	Social Security Number 6. S	ex 7. Age (In yrs	attr Kd	If Under 1 Year			MM/DD/YYYY) 9. Bi	
Director		M 2X F	66 yrs.	Months Days	Hours Min	Dec30	1940	gnMaryland buntry)
· · · · · · · · · · · · · · · · · · ·	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Locatio	on				10d. Inside City Limits
<b>*</b>	Md. Balti	more M	iddle R	liver				1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
ith the M 23a or 2 notified	3809 Dunsmuir	Circle Apt	.L	21220	-2262		U.S.A	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was	Decedent of His es, specify Cubar	spanic Origin? ( S n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
r deat		1 Yes 2 X No		Yes 2 X No	specify:		Specify:	White
ural"	3X XWidowed 4 Divorce  15. Decedent's Education (Specify of	or Dates:	16a. Decedent	's Usual Occupa	tion (Give kind of		6b. Kind of Business	/Industry
5-0036 ed within 72 hour tygiene. tygiene. the Medical Exau	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	ost of working life	. DO NOT use ret	ired)		
036 vithin ene. Er than Medic	6th		Clea	ning L	ady	e (First, Middle, Ma	TMS C1	eaning
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after an of Health and Mental Hygeene. at: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. To Be Completed by F	17. Father's Name (First, Middle, Las		± 0	53	Anna S		iden sumame,	
2121 ould be fill d Mental J s marked tic event,	Vernon Jackso 19a. Informant's Name/Relationship		19b. Mailing	Address (Stree	et and Number or	Rural Route Numb	er, City or Town, Star	te, Zip Cod <b>9</b> )1776
MD 3	Mark T. Tanze	y (son)					<u>New Wind</u>	sor,Md
Te, I and Tealt Healt Fitem	20a. Method of Disposition  1 Burial 2 X Cremation 3		b. Place of Disposi crematory or oth		metery,	Date	20c. Location - City of	or Town, State
Pages lent of nut: 1	4 Donation 5 Other Specif	מו	ayview	Cremat	ory 7-1	<u> 10-2007</u>	<u>Baltimor</u>	e, Maryland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	21. Signature of Funeral Service Lice							al Home, PA
	23a. Part I. Enter the disease, or con	unlications that caused the dea	ath. Do not enter th	OI Dun	dalk A\ , such as cardiac	7e. Ball or respiratory arres	imore,	Approximate Interval
Physician /Medical	failure. List only one cause on	each line.		, ,				Between Onset and Death
aminer	Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries  Due to (or as a consequence	e of):					1
	Sequentially list conditions,	o						
iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequenc	e of):					
ed nisit Examined	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					
		d						
<b>2</b> gring gring page		AMENDED, perME		7/07 <u>TT</u>			23d. Date of deliv	ery
1876 rifficat ing phy as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	2 Fe	etal death 3	Ectopic pregi	nancy	Month	Day Year
Box 68760, e death certificate be the attending physici ed for use as the burn hysician/Med	1 Yes 2 No 9 Unkno	Pregnant at time o	f death 5 O	ther (Specify)			1	
cords, P.O. Box 6876/ law requires that the death certificate has been signed by the attending phy 2 should be detached for use as the transparent of the physician/Mi	Part II. Other significant condition	9 UIKIIOWII	ot resulting in the	underlying cause	given in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
P.O. ss that gened to deta						1 Yes	2 🗸 No 3 P	robably 4 Unknown
Records, I The law requires ficate has been significate by agg 2 should be Completed			· · · · · · · · · · · · · · · · · · ·			24a. Was a		autopsy findings available o completion of cause of
e law i e has t ge 2 sh						perform	ned? death	?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  The law requires that the sertificate has been signed by led in by the funeral director, page 2 should be detacted by entification: To Be Completed by P	25. Was case referred to medical			26.Pla	ce of Death (Chec	k only one)		
F Vital Physician or this cert and director	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien				Residence 6 🗸 Ot	her: Scene
ing Ph After tuneral	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of FOUND:		jury at Work?	28d. Describe h Passenger a	ow injury occurred uto fixed object	collision
sion trendi death. ctor: y the f	1 Natural 5 Pending 2 ✓ Accident Investig	ation Jul 6, 2007	0750 hrs		Yes 2 No	28f Logation /9	treet and Number or	Rural Route Number, City
Division o spiral or Attending nours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could n			eet, factory, office	bullaing, etc.	or Town, So	tate) @ Glenbau	Rural Route Number, City <b>Rd.</b> Rd, Kingsville , MD
C The Basic	29a. Certifier Cortifying Phys	ician: To the best of my know	vledge death occu	irred at the time,	date and place, a	nd due to the caus	e(s) and manner as s	tated.
To the Ho within 24 To the Fin completed	one) 2 Medical Examin	ner:On the basis of examination and manner stated.	on and/or investiga			d at the time, date :		
F × F 2	29b. Signature and title of certifier				nse number		29d. Date signed (	wortin, Day, rear)
	Janu J	eg Mos		0.0	C.M.E. 		July 0, 2007	
5	30. Name and address of person what Tasha Greenberg MD.	o completed cause of death ( Assistant Medical Ex		Penn Stree	t, Baltimore, <b>I</b>	MD 21201		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	R				
Registra	JUL 1	L CHUY SECTION	ORIGINA	N. N.				1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1:08 PM JUM 2007 Kaymond /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not Institution, give street and number) Examiner If Under 24 Hrs. 5. Social Security Number Maryland Medical Center 9. Birthplace (State or Foreign 6 50 **Funeral** Days Hours 08/05/1966 Months 208-56-0870 1**X** M 2 □ F 41 Sellersville, PA Director Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City. Town or Location 10a. State r 28a-f show notified at 1 XYes 2 ☐ No MD Director Greensboro, Maryland Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 506 West Sunset Ave Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. by Funeral 21639 14. Race American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X☐ Never Married 2☐ Married 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 Specify White Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced or than "natura the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many once. Roofer Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond J Vargo Sr ၉ Margaret Eure 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Vargo (Sister) 820 Eastern Road Riegelsville, Pa 18077 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 7, 07| Washington, D C 4 Donation 5 ☐ Other (Specify) Howard Univ School c 21. Signature of Funeral Service Licensee Austin Royster Funeral Home 14th Street N W Washington, D C 20011 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ritoniti /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties of 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? es 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Minpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours the Funeral Dire 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435 F16650 Mes

State Registrar

DHMH 17 Rev 1/2001

raist

31. Date filed (Month, Day, Year)

225, 6 rcene

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Bultimore, MD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Freddie Eugene Weaver, Sr.

1111111	63			1-
2007	4.	ď.	4	5

		1- For State Certifica	ate of	Death	Reg	J. No.	
Physicia Iedical Exami	an/	1. Decedent's Name (First, Middle,Last) FREDDIE EUGENE WEAVER, SR.			2. Date of Death Month July 2, 200	Day Year 7	3. Time of Death 0600 hrs
		Facility Name (if not institution, give street and number)     northbound I-83 prior to Ruxton Road	41	b. City, Town, or Location of I Towson	Death	4c. County of Dea Baltimore Co	
Funeral Director		5. Social Security Number 218-42-8797 6. Sex 7. Age (In yrs. last birt	thday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth Min. 01/16	(MM/DD/YYYY) 9. B / 1947 C	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any rother tranmatic event, the Medical Examiner must be notified at once.	l Director	Elementary/Secondary (0-12) College (1-4 or 5+)	13. Was If Ye  1  Decedent during mo	BALTIMORE  10f. Zip Code 21218  Decedent of Hispanic Origin is, specify Cuban, Mexican, F  Yes 2 X No specify:  's Usual Occupation (Give kir est of working life. DO NOT us  CORIAL SERVI	? ( Specify Yes or No- uerto Rican, etc.)  Id of work done se retired)	White, etc.  Specify: B  16b. Kind of Business  SELF – EM	urican Indian, Black,  LACK  S/Industry
21215- 21215- ould be filed 1 Mental Hyg in marked of ic event, the	Be C	WILLIE LEE WEAVER  19a. Informant's Name/Relationship (Type, Print )  19		RU Address (Street and Number	JTH RAY er or Rural Route Num	ber, City or Town, Sta	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical		20a. Method of Disposition 20b. Place	of Disposit tory or oth LAWN	CEMETERY	Date	20c. Location - City	
Balt permit. Departi Importi		21. Signature of Funeral Service Licensee  Why a  21. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee	46	00 LIBERTY	HEIGHTS	AV, BALT	OME 211207 IMORE MD
Physician /Medical £xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Neck and Chest Injuries  Due to (or as a consequence of):	or enter th	e mode of dying, sour do our	and of respiratory are		Between Onset and Death
tecuted and - transit	Examiner	Sequentially list conditions, if any, leading to immediate course. Enter Underlying Course (Disease or injury that initiated events resulting in death) Last		ş	,		4
iai e e	n/Medical	UNPENDED AMENDED					
Box 68760, re death certificate but the attending physic reference or the attending physic reference as the but re	Physician/Me		2 Fet	ial death 3 Ectopic poer (Specify)	pregnancy	23d. Date of delive	ery Day Year
P.O. es that the igned by	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause given in Parl	1 Yes	2 V No 3 P	to the cause of death?
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should it	Completed				24a. Was a autop perfor	sy prior t med? death	
Vital Rec hysician: The l this certificate I	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/C	Outpatient	26.Place of Death (0		Residence 6 ✓ Otl	ner; Scene
ion of V tending Phy eath. or: After th	ation: To	27. Manner of Death 28a. Date of Injury (Month Day Yagr) 28b.	Time of Ir 2 hrs	njury 28c. Injury at Work?	Driver auto t	now injury occurred fixed object collis	sion
Divisi nital or Att urs after d ral Direct	Certification:	3 Suicide 6 Could not be determined (Specify) Interstate/Expr		et, factory, office building, etc	28f. Location (5 or Town, S northbound I-8	Street and Number or tate) 33 prior to Ruxton F	Rural Route Number, City Road, Towson, MD
Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occur investigat	ion, in my opinion, death occ	e, and due to the caus urred at the time, date	and place, and due to	the cause(s)
	M	29b. Signature and title of certifier  Lasher Leey MAD		29c. License number O.C.M.E.		29d. Date signed (#	Month, Day, Year)
27		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner		Penn Street, Baltimor	e, MD 21201		
S Regis	tate trar	THE TOTAL PRINTED TOTAL PARTY	GOBU				
DHMH 17 Rev 1/2	2001	acus Oi	RIGINA	L			

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December   Action			1 - For State Registrar	State of M	Maryland		artment of H		d Mental Hy	giene Reg. No.	7 22270
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State   Social Secret Norman   Size   Size   2 / Age (0 row) Auto Ordinary   1/10/2007	Exami	ner		_	"				realn		
Decorption of the control of the con	Funeral	- Cap		6. Sex 7. A			If Under 1 Year	If Under 24 I			
The State   The Country   Th				1□M 2风F	77	Yrs.	Months Days	Hours		7 1929	MD
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Henry   Corey   Mable   Sargable    er dea	nuel		Armed Forces	5?	13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin' n, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	- 14. Race - Black,		
Henry   Corey   Mable   Sargable    rs afte	by F		If Yes, Give "	`		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White	
Henry   Corey   Mable   Sargable    2 hou	ted		s Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busin	ess/Industry	
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Physician (Modical Examiner)  Physic			1 Jan 7	30 -							
Due to (or as a consequence of):    Sequentially isst conditions of any leading to immediate cause. Enter Underlying fair immediate cau			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications had cause	ed the death. ling.	Do not ent		g, such as car	diac or respiratory a	rrest,	Approximate
Due to (or as a consequence of):    Sequentially ist conditions, cause. Enter Underlying Last (or as a consequence of):		П	Immediate Cause (Final disease or condition	-a Me	tast	<b>4力(</b>	Luc	16	CANC	ER	6 ment 2th
Due to (or as a consequence of):    Due to (or as a consequence of):			resulting in death)	Due to (or a	is a conseque	ence of):					
Due to (or as a consequence of):    Due to (or as a consequence of):	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	is a conseque	ence of):					
FEMALE   23b Was decedent pregnant   1   1   25c   1   1   25c	ecuter and I-trans	xam	that initiated events	c. Due to (or a	is a conseque	ence of):					
25. Was case referred to medical examiner?  1   Yes 2   Tho   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of cause of death   The part of completion of cause of death   The part of cause of	e be e.			d	1						
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25. Was case referred to medical examiner?  1   Yes 2   Tho   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of cause of death   The part of completion of cause of death   The part of cause of	he dea	yslcl	1 ☐ Yes 2 ☐ No		at time of dea	ath 5	Other (specify)			Month	Day
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25. Was case referred to medical examiner?  1   Yes 2   Tho   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of completion of cause of death   The part of cause of death   The part of completion of cause of death   The part of cause of	aquire en sig								10	Yes 2 N 3	Probably 4 Unknown
25. Was case referred to medical examiner?  1		nplet							autor	osy prio	r to completion of cause of
27. Manney at Death 1 Matural 2 Death 1 Death	The The Icate (	O		,							
29a. Certifier (Crise's only 20 me)  29a. Certifier (Crise's only 20 me)  29b. Signature and till got certifier (Crise's only 20 me)  29b. Signature and till got certifier (Crise's only 20 me)  29b. Signature and till got certifier (Crise's only 20 me)  29c. Licepse number (Month, Day, Year)  30. Name and feddress of person the completed cause of death (Item 23a) (Type, Prht)  State  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Accident and Number or Rural Route Number, afring street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29g. Licepse number (29d. Date signed (Month, Day, Year)  30. Name and feddress of person the completed cause of death (Item 23a) (Type, Prht)  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)	sicier certif irecto	00	examiner?	Hospital:		'D(O	Othe	267		-	
29a. Certifier (Crise's only 20 me)  29a. Certifier (Crise's only 20 me)  29b. Signature and till got certifier (Crise's only 20 me)  29b. Signature and till got certifier (Crise's only 20 me)  29b. Signature and till got certifier (Crise's only 20 me)  29c. Licepse number (Month, Day, Year)  30. Name and feddress of person the completed cause of death (Item 23a) (Type, Prht)  State  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Accident and Number or Rural Route Number, afring street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29g. Licepse number (29d. Date signed (Month, Day, Year)  30. Name and feddress of person the completed cause of death (Item 23a) (Type, Prht)  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)	B Phy er this	11	27. Manner of Death	28a. Date of In		28b. Time of	I 3 DOA	4   Nursir			(Specify)
29a. Certifier (Crieck only one)  29a. Certifier (Crieck only one)  29b. Signature and till got certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and folderss of person the completed cause of death (Item-23a) (Type, Prht)  State  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Date filed (Month, Day, Year)  33. Pegistrar's Signature	ath.	atlo			Day Year)	Injury					
29a. Certifier (Crieck only one)  29a. Certifier (Crieck only one)  29b. Signature and till got certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and folderss of person the completed cause of death (Item-23a) (Type, Prht)  State  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Date filed (Month, Day, Year)  33. Pegistrar's Signature	or Atte	rtifle	determe	288. Place of I	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office	-	28f. Location ( City or Tox	Street and Number ( vn, State)	or Rural Route Number,
30. Name and foldress of person and completed cause of death (Itani23a) (Type, Prht)  State  31. Date filed (Month, Day, Year)  34. Flegistrar's Signature	spital tours a nerel (		29a. Certifier ertifying	Physician: To the bes	st of my know	rledge, death	occurred at the time	ne, date and p	lace, and due to the	cause(s) and mann	er as stated.
30. Name and foldress of person and completed cause of death (Itani23a) (Type, Prht)  State  31. Date filed (Month, Day, Year)  34. Flegistrar's Signature	he Ho in 24 h he Fu		(Check only 2   Medical E	xaminer: On the basis	of examination	on and/or in	vestigation, in my or	oinion, death o	occurred at the time,	date and place, and	due to the cause(s)
State 31. Date filed (Month, Day, Year) 3 Pegistrar's Signature	To t To t	Σ	29b. Signature and title of certifier	1	1 51	4 ,	29c. Liceose	200	964	29d. Date signed (A	Month, Day, Year)
State 31. Date filed (Month, Day, Year) 3 Pegistrar's Signature	1		30 Name and Advance of parents	no completed cause of	death (Ital	23a) (Type	Print) IV	- 0	1 )	27/1	0/07
1111 4 4 200	φ		Elliott &	1076afy	14/1	Mu	dion for	KY	True ble	a Bushie	hd, 2106/
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			1 - For State Registrar	State of Maryland		rtificate of			JIENE Reg. No.	2001	66611
	Physici	an	1. Decedent's Name (First, Middle, Las	A/EX	LOPUL	-05		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			r Location of Death			ounty of Death	1 (7/0
<i>ų</i> .		*	1010 Poplar Aver.  5. Social Security Number 6. S		et hirthday)	A If Under 1 Year	nnapolis  If Under 24 Hrs.	8. Date of Birth		Anne A	
ú	Funeral Director			M 2□F 83	Yrs.	Months Days	Hours Min.	March 8	r, Year)	24	nplace (State or Foreign untry) New York
	Maryland a-f show ified at	ctor	10a. State Maryland Anne Ar		, Town or Lo		napolis				10d. Inside City Limits  ↑★★ es 2 □ No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 1010 Poplar Avenu	le		10f. Zip Code	1401	10g. Citize	U.S.A		
0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give 1943-5 Year or Dates		Vas Decedent of H f Yes, specify Cub I ☐ Yes 2  No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		4. Race - Amer Black, White Specify:	
2	in 72 hc n "natu fedical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Deced (Give life. D	lent's Usual Occup kind of work done OO NOT use retired	pation during most of wor d)	king	16b. Kind	d of Business/i	industry
7 7	ed with ygiene. ier thai	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		Restaur	anteur			Restaur	ant
/land	ould be filed v Mental Hygie narked other t natic event, th	To Be	17. Father's Name (First, Middle, Last) Alexios Alexopul					ne (First, Middle, a Vitsas	Maiden S	iurname)	
Mar	und 2 sho alith and 27 is ma er traums		19a. Informant's Name/Relationship ( Elizabeth Alexop	file in the second seco		g Address (Street Poplar A	and Number or Ru Venue Ar	napolis			<sup>(ip Code)</sup> 21401
Hore,	Pages 1 and the ment of the sant: If item		20a. Method of Disposition  1 ★ Gurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 5 □ Other (Specification)			sition (Name of natory or other plan rios Ceme		Date /26/2007		ation - City or	Town, State  Maryland
Баппо	permit. I Departm Importar any inju		21. Signature of Funeral Service Licer	1 10	22	. Name and Addre	ss of Facility Jo	ohn M. Ta	aylor	Funera	al Home
	ED = 10 G		23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the death						aports	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Evo Slage Due to (or as a consequ	C	1PD					Onset and Death Livery
	Examiner	ı.	Sequentially list conditions,	b. Due to (or as a consequ							
	scuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
08/00,	ificate be executed g physician and as the burial-transit	edical Ex	leading in death) cast	Due to (or as a consequent	ence of):						
	E D 6		IF FEMALE:	00-14							
C. BOX	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3□	]Ectopic pregnanc ] Other <i>(specify)</i> _	у		23	3d. Date of deli Month	ivery Day Year
Γ.	res that t signed by be detar	Ď	Part II. Other significant conditions	ontributing to death but not resu	Iting in the ur	nderlying cause giv	en in Part I.		obacco us	,	the cause of death?
ecoras	w requi	Completed						24a. Was	an	24b. Were au	ntopsy findings available
E 76	: The law cate has b ; page 2 sl	Comp							rmed? 2 No	prior to death? 1 ☐ Yes	completion of cause of 2 ☐ No
<u> </u>	Physician: r this certific ral director,	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 8	ER/Outpatien	t 3 DOA Oth	or:	ath <i>(Check only o</i> Home 5 Resid		□0#/2	-14.4
on or	ng Phy fter this ineral d	on: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of injury	· OLI DON	4 Linuising F	28d. Describe h			uny)
NISIO	Attendi death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At ho	me, farm, stre		Yes 2 No	28f. Location (5	Street and	Number or Ru	ıral Route Number,
2	Ital or / rs after ral Dire	Certi	4 ☐ Homicide determined	building, etc. (Specify	·)			City or Tou	vn, State)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical		nysician: To the best of my knowniner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my	opinion, death occu	urred at the time,	date and	place, and due	e to the cause(s)
)	withir View of To #	) Me	29b. Signature and title of certifier	completed cause of death (Item NA My 445 32. Relistrar's Signat	m	29c. Licens	21438		29d. Date	signed (Monti	h, Day, Year)
1	The state of the s	7	30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) FENSE /	+16HWA-	1 ANNI	4800	is Mi	21401
e)	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 5 2	32. Refistrar's Signat	ure	(made)					
DH	MH 17 Bey 1/2	001		7-000	- 17						

DHMH 17 Rev 1/2001

Accounty of Death Aberdeen   Accounty of De	ntry) MD  10d. Inside City Limits 1 X Yes 2 No  No  No  No  No  No  No  No  No  No
4a. Facility Name (if not institution, give street and number)  CSX railroad MM 63.1  5. Social Security Number  218-13-3044  1XM 2 F  20  Yrs.  6. Sex  218-13-3044  1XM 2 F  20  Yrs.  7. Age (in yrs. last birthday)  Yrs.  8. Date of Birth (MM/DD/YYYY)  9. Birthple Foreign Count  Winn.  Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Aberdeen  10f. Zip Code  10g. Citizen of What Country  10g. Citizen of What Country  11. Marital Status  11. Marital Status  11. Marital Status  11. Marital Status  11. Marital Status  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  14b. City, Town, or Location of Death  Aberdeen  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  4c. County of Death  Harford  8 / 11 / 1986  8 / 11 / 1986  8 / 11 / 1986  10g. Citizen of What Country  U.S. A.  Armed Forces?  1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes, specify White, etc.	place (State or htry) MD  Od. Inside City Limits  1 X Yes 2 No  No  No  No  No  No  No  No  No  No
CSX railroad MM 63.1  Aberdeen  Funeral Director  Funeral Director  Social Security Number	ntry) MD  10d. Inside City Limits 1 X Yes 2 No  No  No  No  No  No  No  No  No  No
Director  218-13-3044  1 X M 2 F 20  Yrs. Months Days Hours Min. 8/11/1986  Foreign Count  Usual Residence of Decedent  10a. State 10b. County  MD Harford Aberdeen  10c. City, Town or Location  Aberdeen  10f. Zip Code  10g. Citizen of What Country  11. Marital Status  1 X Never Married 2 Married  1 X Never Married 2 Married  1 X Never Married 2 Married  1 X Never Married 2 Married  1 X Never Married 2 Married  1 X Never Married 2 Married  1 Yes 2 X No Specify: White	ntry) MD  10d. Inside City Limits 1 X Yes 2 No  No  No  No  No  No  No  No  No  No
The state of the s	1 X Yes 2 No  y?  an Indian, Black,
MD Harford Aberdeen    10f. Zip Code   10g. Citizen of What Country   10g. Citizen of What Co	ry? an Indian, Black, te
11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Ves. Give Year 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 X No. Specify 1 X No. Specify 2 X No. Specify 3 Widowed 4 Divorced If Ves. Give Year 1 Yes. 2 X No. Specify 3 Widowed 4 Divorced If Ves. Give Year 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 Yes. 3 X No. Sp	an Indian, Black,
11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Ves. Give Year 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 X No. Specify 1 X No. Specify 2 X No. Specify 3 Widowed 4 Divorced If Ves. Give Year 1 Yes. 2 X No. Specify 3 Widowed 4 Divorced If Ves. Give Year 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 Yes. 2 X No. Specify 1 Yes. 3 X No. Sp	te
1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Write, etc.	te
3 Widowed 4 Divorced If Yes Give Yeer 1 Yes 2 Xt No specify: Specify: Whit	
	lustry
3 Widowed 4 Divorced If Yes, Give Yeer or Dates:  1 Yes 2 No specify: Specify: White Specify: Specify: White Specify: Specify: White Specify: Specify: White Specify: Specify: White Specify: White Specify: Specify: Specify: White Specify: Specify: Specify: Specify: White Specify: Specify: Specify: Specify: Specify: White Specify: Speci	;
9 COok  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	nt
17. Father's Name (First, Middle, Last)	
Property of the state of the st	Zin Codel
Kathleen Ann Travers (Mother) 634 Jennifer Lane Aberdeen, Maryland	21001
20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To	
Tarring—Cargo Funeral  Los Methods of Bisposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Tarring—Cargo Funeral	· · · · · · · · · · · · · · · · · · ·
Burial 2 X Cremation 3 Removal from State R. A. Ferris & Co. 7/9/07 West Chester R. A. Ferris &	Home, P.A.
Physician 23a. Part I. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple injuries	Death
or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
Due to (or as a consequence of):	
X UNPENDED	
O and the second	ay Year
So the first state of the first	
O to be significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 9 Unknown  9 Unknown  1 Yes 2 No 9 Unknown  1 Yes 2 No 9 Unknown  1 Yes 2 No 9 Unknown  1 Yes 2 No 9 Unknown  23e. Did tobacco use contribute to the part I.	ne cause of death?
1 Yes 2 ✓ No 3 Probat	
Yes 2 No 3 Probact  The law radaries 1 of 1 of 2 of 3 of 3 of 3 of 3 of 3 of 3 of 3	opsy findings available impletion of cause of
autopsy prior to con death?  1 ✓ Yes 2 No 1 ✓ Yes	
24a. Was an autopsy performed?  1	
examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other 4   Nursing Home 5   Residence 6   Other: S	Scene
Company of the struck by tree to be a struck	
Pedestrian struck by translation or Town, State)  Natural 2 X Accident Since of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Natural 2 X Accident Since of Injury - At home, farm, street, factory, office building, etc. or Town, State)  See. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  See. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  See. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  See. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  See. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	
So the latter of	
0 = 5   129a, Cerumer   6 ar = 1 ar = 1 ar	d.
The first of the conty of the cause(s) and manner as stated.  The first of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The first of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The first of the first of the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The first of the firs	
O.C.M.E. July 8, 2007	
30. Name and address of person who completed cause of death (Item 23a)	
Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year)  Registrar  JUL 1 1 2007  Registrar	
DHMH 17 Rev 1/2001 ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Rebecca Butler Mamie June 22 2007 10:52 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Charles Civista Medical Center La Plata 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs. Director 217-44-5415 63 02/13/1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r 28a-f shov notified at 1XYes 2 No Directo Charles Maryland Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 3006 Gallery Place Apt T-7 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian. Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Black 2 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည William Dyson Mary Washington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Butler/ Daughter 15360 Homeland Dr. Hughesville, Maryland20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Marys 6/28/07 Bryantown, Maryland 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of veral Service License 191 20605 Aquasco Road Aquasco, Maryland20608 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ischemic bowel Immediate Cause (Final Physician days disease or condition resulting in death) /Medical Due to (or as a consequence of): Years atheroscieros is Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-tran Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 mellitus, CVA, hypothyroidism 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? res 2D No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760,

with the Maryland

Maryland 2121

Baltimore,

Name and address of person who completed cause of death (item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6/22/07

R. Sindhun

and manner stated.

RAVINDER SINDHWANI 11350 PEMBROOKE SQ. SUITE 304 WALDORF, MD. 2008 MD Restrar's Signa

D-61614

State Registrar

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Daniel Albert Beckne	State of Marylar	nd / Department of Health a Certificate of Death		2007 2227
	Registrar  1. Decedent's Name (First, Middle,Last)	Certificate of Beatif	2. Date of Dea Month	5 1/
Medical Examiner	Daniel Albert Beckner		July 5, 20	07 Year 0055 hrs
	4a. Facility Name (if not institution, give street and num Anne Arundel Medical Center	ber) 4b. City, Fown Annapoli	, or Location of Death S	Anne Arundel
Funeral	5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday) If Under 1		rth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	219-29-4251   1X M 2 F	22 Yrs. Months	Days Hours Min. June .	3, 1985 Country) Maryland
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
*	Maryland Anne Arundel		Annapolis	1 Yes 2 X No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene ant. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	10e. Street and Number 512 Tayman Drive	10f. Zip Coo	21403	10g. Citizen of What Country? U.S.A.
r death with or items 23 must be no	11. Marital Status  1 XXNever Married 2 Married Armed For		f Hispanic Origin? (Specify Yes or Nuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
er deat , or ite r mus	1 Yes  Widowed 4 Divorced If Yes, Give Year	2XX No 1 Yes 2 X	No specify:	Specify: White
atural" atural"	15. Decedent's Education (Specify only highest grade	e completed) 16a. Decedent's Usual Occ	upation (Give kind of work done glife, DO NOT use retired)	16b. Kind of Business/Industry
16 n 72 ho nan "na ical Ex	Elementary/Secondary (0-12) College (1-12)	4 or 5+)	ctrician	Electrical
215-0036 be filed within 72 hour ntal Hygiene riced other than "natt ent, the Medical Exa Be Completed	17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle,	Maiden Surname)
215 be filed ntal Hy rrked o ent, th	Robert Beckner		Karen Tschan	Contract Tim Code)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med To Be Comi	19a. Informant's Name/Relationship (Type, Print)  Karen Beckner/mother		Drive Annapolis	mber, City or Town, State, Zip Code)  Maryland 21403
and 2 and 2 lealth a	20a. Method of Disposition	20b. Place of Disposition (Name of		20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr	1 Burial 2 X Cremation 3 Removal from Donation 5 Other Specify:	Baltimore Crema	atory 7/7/2007	Baltimore, Maryland
Baltii permit. Departm Importa	21. Sign time of Funer Service Licensee	22. Name and Ad		Taylor Funeral Home
Physician	23a. Part I. Enter the disease, or complications that ca	used the death. Do not enter the mode of d	ying, such as cardiac or respiratory a	t., Annapolis, MD 21401 rrest, shock, or heart Approximate Interval Between Onset and
M. dical	failure. List only one cause on each line.	and benoin intexication		Death
( aminer		consequence of):		
Ē	if diffy, loading to minimum to	consequence of):		
ted nisit	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a	consequence of):		
0, e be executed ysician and burial - transit edical Exe	d			
0, e be execut vsician and burial - tra	X UNPENDED AMENDED 7	27,28a-f, perME, g869, 7/	13/07 TT	23d. Date of delivery
6876( ertificate ding phy e as the b	23b. Was decedent pregnant in the		3 Ectopic pregnancy	Month Day Year
Box 6876 e death certificate the attending phy ed for use as the U	1 Yes 2 No 9 Unknown 9 Unknown	ant at time of death 5 Other (Specify	)	
م اعہد غہ	Part II. Other significant conditions contributing to		tude given in t airt ii	tobacco use contribute to the cause of death?
, P.O. res that the signed by be detac				Yes 2 ✓ No 3 Probably 4 Unknown
ords w requires been should				as an 24b. Were autopsy findings available prior to completion of cause of death?
Records, The law require ficate has been signage 2 should b. Completed			1 <b>✓</b> Ye	
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should bertification: To Be Completer	25. Was case referred to medical examiner? Hospital:	Inpatient 2 ✓ ER/Outpatient 3 DO	Place of Death (Check only one)  Other  Nursing Home 5	Residence 6 Other:
of Vige Phys free this neral di	1 Yes 2 No 28a, Date	of Injury 28b. Time of Injury 28		be how injury occurred
ion ttendin leath. for: A rthe fu	1 Natural 5 Pending 7.4.2	2007 FNd 11:55 pm	1 Yes 2 X No unk	n (Street and Number or Rural Route Number, City
Division or spital or Attending on safer death. neral Director: After filled in by the firme Certification:	3 Suicide 6 X Could not be determined (Specify)	e of Injury - At home, farm, street, factory, o	or Towr	n (Street and Number of Rufal Route Number, City n, State) ere Community Marina. Annapolis
O file of pi	4 Homicide	st of my knowledge, death occurred at the ti	me, date and place, and due to the c	ause(s) and manner as stated.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification: To Be Con	(Check only one)  2 Medical Examiner: On the basis and manner s	of examination and/or investigation, in my ostated.	pinion, death occurred at the time, da	ate and place, and due to the cause(s)
F % F %	29b. Signature and title of certifier		License number  O.C.M.E.	July 5, 2007
	30. Name and address of person who completed cau			
204		Medical Examiner 111 Penn St	reet, Baltimore, MD 21201	
State		s strar's Signature	•	
Registra  DHMH 17 Rev 1/2001	301-3	ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 07 **Physician** LIZABETH BUTLER 2150 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1498 Kingsway Court Gambrills If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2XF **Director** 230-50-5951 67 Jan.11,1940 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Anne Arundel Gambrills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1498 Kingsway Court 21054 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyglene.
suit: If item 27 is marked other than "natural", or items 23a ury or other traumatic event; the Medical Examiner must Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Verizon telepone CO. Elementary/Secondary (0-12) College (1-4or 5+) Communications Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Avery Clinton Butler Willie Marie Ashburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troope. Court, Gambrills, MD 21054 Linda A. Smith /Friend 1498 Kingsway 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 26, 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Alexandria, VA. Metropolita Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie,MD 20715 23a. Part1. Enter the disease shock, or heart failure. I complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No affer death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29b. Signature and title of certifier M CU 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

Chief Medical Officer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospice of the Chesapeake, 445 Defense Highway, Annapolis, MD 21401

D21438

Michael J. LaPenta, M.D.,

me 26, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) JONE 2007 5:35 P M 1<sup>1</sup>8<sup>y</sup> **Physician** BRCOKS MARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY GLADYS SPELLMAN NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1□ M 2₩ F 1933 VIRGÍNIA 579-40-3592 April Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State r than "natural", or Iteme 23s or 28s-1 show the Medical Examiner must be notified at ¥ Yes 2 No LANDOVER PRINCE GEORGE'S MT Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20785 U.S.A. 6716 VERMONT COURT Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
In nortant: if Item 27 is marked other than "natural", or Item
any hury or other traumatic event, the Medical Exempter
anguage. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2☐ No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ENGINEER 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNKNOWN CLAYTON WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1208 JAVA PLACE LANDOVER, MARYLAND 20785 TITINA EASON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN CEMETERY 6/26/2007 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LV: btic Physician /Medical Due to (or as a consequence of): meamone 20 to cupwater Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examine montes this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-fransit The law requires that the death certificate be executed wone Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovasculor acudent Diabeteo med frain 1 Yes 2 No 3 Probably 4 Unknown Completed Incider dependent 24b. Were autopsy findings available prior to completion of cause of death? Commony arlen 24a. Was an autopsy performed Analmes Chrone discase 1 Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours after the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier \$0 D24720 1810 was RAVINDER K. PRISTAGI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20785 LAND OVER 6132 ROAD CHEVERLY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3:25 A M Eleanor O. Browning June 20, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4317 Elm Street Chevy Chase Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1□M 2X F Director Mar 28, 361-32-3233 96 1911 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified 1 XYes 2 No Directo MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygene.

Department of Health and Mental Hygene.

Them 27 is marked other than "natural", or items 23a or my injury or other traumantic event, the Medical Examiner must be rany filed. 4317 Elm Street 20815 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Bleck, White, etc. ☐Yes 2X No f Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2☐XNo Specify: ≥ Specify: 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Leonard Oechsli Loula Boicourt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Browning/daughter 4317 Elm Street Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 06/21/07 Beltsville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed the bunal-tra resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2X No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was en 1 Yes 2 XNo the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending investigation Injury 1X Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64615 June 20, 2007 (M)

(10 M)

Division or Vital Records. P.O. Box 68760.

Saltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

JUN 2 2 2007

32. Fegistrar's Signature

ignature forth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Genevieve Wroblewski, M.D. 1355 Piccard Drive Rockville, MD 20850

State

Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:35 p<sup>M</sup> Claude Joseph Bailey Jr. 2007 June 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6123 Twin Point Cove Road Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Sept. 26,1924 Washington, DC 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1X M 2 □ F 579-20-9694 82 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No MT) Dorchester Cambridge "natural", or items 23a or 28a-f sl edical Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6123 Twin Point Cove Road 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1∑Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white ò 3 ₩ Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) the law enforcement police officer 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claude Joseph Bailey Catherine Osterman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. Kathleen Andrews daughter 6009 89th Ave., New Carrollton, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 6/22/07 Salisbury, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non **Physician** Hodg Kins ears /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s After this certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ဥ 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Bramble St 31. Date filed (Month. Day State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#7, 8perFH6/26/07, BMW, McCo Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Barbara E. Buckner 06/23/2007 6:58pm M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Cceverly Prince George's Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day 1960 Social Security Number ast birthday) **Funeral** Days 1 □ M 2 🔀 46 Hours Washington, DC 577-90-1557 **Director** 10/07/43Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, <u>the Medical Examiner must be notified</u> at Md 1X Yes 2 □ No P.G. Director Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20745 5542 Knoll Dr USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George C. Williams 은 Barbara Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eastmond Buckner Husband 7627 Greenleaf Rd. Landover Md 20785
of Disposition (Name of 200. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: if ite
any injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 06/29/07 Landover, Md 4 Donation 5 Other (Specify) Harmony Memorial 22. Name and Address of Facility Snead Mortuary Service, P.a. 21. Signature of Funeral Service License 1409 Fairlakes Pl Ste B Bowie , Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition This **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an his certificate has b I director, page 2 sh 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 🙀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 | Yes 2 | No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director;
completely filled in by the 1

> State Registrar

DHMH 17 Rev 1/2001

Medical

MICHAEL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 egistrar's Signature

29a. Certifier

(Check only one)

29b. Signature and title of certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

CHEVERLY, MD 20785

			1 - For State Registrar	State of Ma	ryland / [		artmen tificate			and M		giene Reg. No	600	7	222	280
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Jurgis		E	31ek	aitis				2. Date of De. June		y 200 <b>%</b> °		3. Time of 0 8:27A	
	Examir		4a. Facility Name (If not institution, give s 8486 Snowden Oaks	Place			I	aure					County of D	Geo		
ľ	Funeral Director		5. Social Security Number 345~26~0484 6. Sex	7. Age	(In yrs. last bir	Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birt (Month, Da July 8,	y, Year)	17 F	Sirthplac Country 1nl a	e (State or nd	Foreign
	Maryland B-f show	tor	10a. State 10b. County Maryland Prince Ge		10c. City, Tow Laure		cation							10d	. Inside City	•
	th with the 23s or 28	al Dire	10e. Street and Number 8486 Snowden Oaks I	Place			10f. Zip	Code 0 <b>7</b> 08					izen of What nited			
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f show any rolury or other traumatic event. I'm Medical Examinating in cultiled at angle.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Orig n, Mexican Specify:	jin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	•	14. Race - Ar Black, W Specify:			:e
Baltimore, Maryland 21215-0036	id within 72 h giene. er then "natu	Sompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		)	(Give i	OO NOT us	k done d	uring most	of worki	ing		Lithu			vice
yland	should be file ind Mental Hy marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last) Adomas	B <b>l</b> ek	aitis				18. Mother Elen		(First, Middle,	Maiden		lups	ska	
, Mar	and 2 sh ealth and m 27 le m		19a. Informant's Name/Relationship (Typ. Grazina Blekaitis	oe, Print) -wife	84	486	Snow	len (		Plac	e Laure					
imore	Pages 1 Iment of H lant: If Ite jury or otl		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. Place of cemeter Metro	ni cram	atom or at	hor alacc	otory		5/2007		cation City xandri			nia
Bai	Departi Departi Importa any inji		21. Signature of Funeral Service License	Shomes		D6:	nald 00 Po	V•ddr⊕B wder	orgwe	rdt Roa	Funera: ed Belts	l Ho svil	me, PA le, Ma	ry1	and 20	0705
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	e cause on each line	e to Th	nriv		of dying	, such as o	cardiac o	r respiratory ar	rest,		In	pproximate terval Betwo nset and De Month	een eath
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Alzhei	mers Di		se							8	ycars	b: 1
8760,	ficate be executed physicien and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence (	of):										
P.O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal deeth		Ectopic pre Other (spe					4	23d. Date of o	lelivery Da	ıy Ye	ear
Records, P	w requires that been signed t should be det	ted by Pl	Parl II. Other significant conditions cont Coronary artery dis						n in Part I.		23e. Did to	_	se contribute		cause of dea	
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VItal	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	4 T 50/0		-0	Othou			Check only or					
DIVISION OF	Attending Physician: r death. ector: After this certific by the funeral director.	H-16	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		ime of njury		c. Injury Work	4   Nur	2	ne 5 🕅 Resid 18d. Describe h			oecify)		
N N	P affer □	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	(Specity)						8f. Location (S City or Tow	n, State,	)			97,
	P Fun	ledical	29a. Certifier 1 Certifying Physic Check only one) 1 Medical Examination	cian: To the best of er. On the basis of e and manner state	Kammation and	, death wor inve	occurred a	t the time n my opi	e, date and nion, death	place, a occurre	and due to the co	ause(s) late and	and manner place, and d	as state ue to th	d. e cause(s)	
	To the comple	2	29b. Signature and title of certifier	augor	aite	24	り	License 1309	)1			Jun	e signed (Mo	200	7	
			30 Name and address of person who con Saulius Naujokaiti			Type, P	rint) X1CO	Ave.	,N.W.	<b>,</b> #3	49 Wash	ingt	on, D.	C.	20016	
	Sta		31. Date filed (Month, Day, Year)	32 egistrar	s Signature	La	all I									

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Blamick Lois TUNY. 2007 4c. County of Death 4a Pacility Name (If not institution, give street and number) Dalisbury WICOMICO Medical Center KegioNA eninsula If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Pay, Year) 5/11/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 207-16-9813 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No McKeesport PA. Allegheny 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 107 Mount Vernon Drive 15135 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Freda Seitz Morelle Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Mount Vernon Drive McKeesport, PA. 15135 19a. Informant's Name/Relationship (Type. Print) Robert S.Blamick/Husband 6/2<sup>Pgte</sup>/2007 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Penn-Lincoln Mem.Pk 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State North Huntington, PA 4 Donation 5 Other (Specify) Funeral Service License 21. Signat re PHILIP AD A POST PORTO PORTO PARAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years Due to (or as a prosequence of): Multi URSSEL cittlenes tell vitettrains if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show at

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Items 2

'natural", or

ulth and Mental Hygiene. 27 Is marked other than " r traumatic event, the Me

Department of Health ar Important: If Item 27 Is any Injury or other trau once.

the Medical

must be notified

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine and attending physician for use as the buria Physician/Medical þ Completed Be 2 After t Certification: after death | Director: | d in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☐ Natural

autopsy performed? 1 Yes 2 X No

28d. Describe how injury occurred

25. Was case referred to medical examiner?

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 3041211 29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Hospital:

St. SALisbury Md. 31. Date filed (Month, Day, Year)

State Registrar

**JUN 26** 2007



within 24 hours aft To the Funeral Di completely filled in

Medical

			For State Registrar	State of Ma	-		nt of Healt <i>te of Dea</i>			giene Reg. No. (	2007	22282
			1. Decedent's Name (First, Middle,	Last)		-			2. Date of De	ath Day	Year	3. Time of Death
	Physicia Medic/		Frances Herron	Canning				J	lune 24	200	7	11:30 a M
	Examin		4a. Facility Name (If not institution, g	jive street and number)		4b. Cit	y, Town, or Locat	tion of Death		4c. C	ounty of Deat	h
	8	51	14109 Beechvue				ver Spr	ing nder 24 Hrs.	O Data of Dia		gomery	
	uneral		,	. Sex 7. Age 1 ☐ M 2 👿 F	e (In yrs. last bir 95	Yrs. Months		urs Min.	8. Date of Bir (Month, Da	ay, Year)	Co	hplace (State or Foreign untry)
<sub>o</sub> Di	irector		578-26-1709 Usual Residence of Decedent	X		110.			Dec 14,	1911	0	H
and	T T		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
Maryl	f sho	ō	MD Montgom	erv	S	ilver S	bring					1xxxYes 2 □ No
the	28a notif	rec	10e. Street and Number			1	ip Code			10g. Citize	en of What Co	untry?
with	3a or	<u> </u>	14109 Beechvue I	ane		2	0906			USA		
<b>5-0036</b> 72 hours after death with the Maryland	ms 2 mus	Funeral Director	11. Marital Status	12. Was Decedent E	Ever in U.S.		edent of Hispani ecify Cuban, Me	ic Origin? (Sp	ecify Yes or No		1. Race - Ame	
affer	or Ite		1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	No			exican, Puerio ec <i>ify:</i>	nican, etc.)		Black, White	e, etc.
OUSO hours af	ral", c Exan	ò	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I LI Tes	ZALINO SPE	всиу.		8	Specify: Whi	te
2 Pc 22	natu	Completed	15. Decedent's	Education grade completed)	16a.	Decedent's Us	vork done durina	most of work	dng	16b. Kind	d of Business/	Industry
i ii g	Mec	훁	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT	use retired)		_			
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De fill	d off even	å	17. Father's Name (First, Middle, La								umame)	
yld Dould	narke	유	Harold H. Herror		10h	Mailing Addro	ss (Street and N		Stewar		Town State	Zin Cada)
Man d 2 st	7 Is n traun		Elizabeth A. Canning			Ü	ue Lane,					cip Code)
and H	em 2		20a. Method of Disposition	/ Daugnter	20b. Place of	f Disposition (N	ame of		Date		ation - City or	Town, State
Pages	Important: If them 27 is marked other than "natural", or leams 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		MBurial 2 □Cremation 3			ry, crematory o	, ,					
ICIN it. Pr	nicr)		4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		Gate of	Heaven C	<b>emetery</b> and Address of F	Jun 29, Facility	141 H 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Spring,	
<b>Daliti</b> Permit.	any		) molien	XICOLO	/			Fran				Home Inc.
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused	the death. Do		ersity Bloode of dying, suc				MD 50301	Approximate
Di			shock, or heart failure. List of Immediate Cause (Final	ily one dause on each lir	ne.							Interval Between Onset and Death
	rsician Iedical		disease or condition resulting in death)		a consequence		scular Di	sease			-	1 year
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	the at ned fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of death	5 Other	(specify)					
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<u> </u>	cate has b page 2 s	npl							24a. Was	opsy ormed?	prior to death?	utopsy findings available completion of cause of
<b>교</b> :	icate	S							1□ Yes	<b>X</b> X No	1 ☐ Yes	2 □ No
Or VITA Physician:	: After this certificate tuneral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	444		Other:		th (Check only			
o a	rthis raldi	<u>유</u>	1 ☐ Yes 2X No 27. Manner of Death	1 ☐ Inpatie		utpatient 3 Time of	DOA 4	☐ Nursing H	ome XX Res			ocify)
e fig	Affel fune	tion	XX Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day		Injury M	28c. Injury at Work? 1 ☐ Yes	2 □ No		,,		
VISION Attending	ctor:	fica	3 Suicide 6 Could no	ot be 28e. Place of inju	ury - At home, fa	arm, street, fact	ory, office	-			Number or R	ural Route Number,
בון בון	d in b	Certification:	4 ☐ Homicide determin	building, et	c. (Specify)				City or To	own, State)		
spita	neral / fille			Physician: To the best								
ie Ho	ne Funeral Director: Alpha pletely filled in by the fur	edical	(Check anly 2 Medical E	xaminer: On the basis of and manner sta		nd/or investigat	on, in my opinio	n, death occu	rred at the time	e, date and	place, and du	e to the cause(s)
To th	To the complet	Me	29b. Signature and title of certifier	//		/.	29c. License num	nber		29d. Date	signed (Mon	th, Day, Year)
1			1 Atrim	77 rum	- , p		D08381			Juma 2	5, 2007	
·			30. Name and address of terson w	o completed cause of d	leath (Item 23a)	(Type, Print)				Juli 2		
			Benjamin Avrunin, M.			hilip Dr	Suite 20	9, Olne	y, MD 208	332		
	Sta	ate	31. Date filed (Month, Dely, Year)		rar's Signature	hoost	9					

			For State Registrar	State of Mary		artment of <i>rtificate c</i>				iene       og. No.	i I	44600
		Ξ	Decedent's Name (First, Middle, Last)			involute a			2. Date of Deat	h		3. Time of Death
	Physici /Medio		Mary	A		Dors	еу		June	23 200	Year )7	11:35p M
	Examir		4e. Fecility Name (If not institution, give	treet and number)		4b. City, Tow	n, or Location	n of Death		4c. County		
			742 University	<del></del>			aldor				rles	
	Funeral		5. Social Security Number 6. Sex	M 057 E	yrs. last birthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Birth (Month, Day, 06/02/	Year)	9. Birthp Coun	lece (State or Foreign try)
	Director		215-38-6484  Usual Residence of Decedent	M 2MF 70	, ,,,,,				06/02/	1937	Mar	yland
	yland		10a, State 10b, County	100	c. City, Town or Lo	cation					1	0d. Inside City Limits
	a-fat	oto V	Maryland Charle	S	Wal	dorf						1 X Yes 2 □ No
	or 28	Jire	10e. Street and Number			10f. Zip Cod	е		1	0g. Citizen of W	hat Coun	try?
	ath w	rai	742 University			1	0602			USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show other traumatic event, the Mudical Exp. cities is also be nuitilised at	d by Fune	Iaryland Charle 10e. Street and Number 742 University 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C			cify Yes or No- lican, etc.)	Blac	e - Americ k, White, Blac	etc.
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isic	Attending or death. ector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home, form, etc.		Yes 2		8f. Location (Str	root and Alumba	s of Pura	Davida Mumbas
Division	after Direct In by	Certification:	4 ☐ Homicide determined	building, etc. (S)	pecify)	eet, ractory, one	CO		City or Town		or Huta	noule Number,
_	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  2 UMedical Examirone)	ician: To the best of my er: On the basis of exam	knowledge, death mination and/or inv	n occurred at the vestigation, in m	e time, date a	and place, a eath occurre	nd due to the ca d at the time, da	use(s) and mar ate and place, a	nner as stand due to	ated. the cause(s)
	othe ithin 2 o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Lici	ense numbe	r	29	d. Date signed	(Month, I	Day, Year)
	F ≯ F 8		Marias	MM	M	0	2 C	35	)	6	125	107
0			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Tyna	Print)	15	7),		0/	0 1	/
	B2		31. Date filed (Month, Day, Year)	32. Pegistrar's S	1703	6	Plefo	=	MD	20	64	6
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			1 - For State Registrar	State o	f Marylar		artmen rtificate			and M		giene Reg. No. C	2007	222	8.
н	Physici	an	Decedent's Name (First, Middle		.1 -	_					2. Date of De Month	Day	Year	3. Time of [	
	/Medic	al		even Jose		Prenda				(5. 1	June	25,	2007	12:56	PM
	Examin	er	4a. Facility Name (If not institution 2227 Regina		mber)			rksb	Location o	of Death			ounty of Deat		
	Funcial		5. Social Security Number		7. Age (In yrs.	last birthday)		1 Year		24 Hrs.	8. Date of Bir	th	ederic	K hplace (State or	Foreign
	Funeral Director		219-48-4574	6. Sex 1 ☐ M 2 ☐ F	59		Months	Days	Hours	Min.	(Month, Da May 2,	y, Year)	Co	untry) (land	, c. c.g.
			Usual Residence of Decedent				1								
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	death with the Marylar ne 23e or 28e-f ehow must be notified at	Directo	Maryland Frede	rick	Cla	rksbur								1 🗌 Yes	~ [V] (A)
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	fter dea	Funeral	1 ☐ Never Married 2 👿 Marr	Armed Fo	rces?	1			in, Mexican	, Puerto	ecify Yes or No Rican, etc.)	.	Black, White		
3	hours after death with the Maryland tural; or Iteme 23e or 28e-f ehow al Exoniner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes If Yes, Gir Year or D	/e <sup>21</sup> ates:		1 ☐ Yes	2X No	Specify:			S	pecify: Wh	ite	
5-0036	n 72 ho "natur edical	Completed	15. Oeceden (Specify only highes				dent's Usua		ation during mos	t of worki	ina	16b. Kind	of Business/	Industry	
7	within 72 ene. then "nat	nple	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT us	se retired	1)		9				
	filed w Hygier other th		17 Fathada Nama /First Middle	4		Police	eman/1	Dete			/Cimt Mintella		Enforce	ement	
anc	ag la b	Be	17. Father's Name (First, Middle,		1_						(First, Middle,		umame)		
Maryland 2	2 should and Men le marke eumatic	J.	Salvatore Jose  19a. Informant's Name/Relations.		ıa	19h Mailie	na Address	(Street			h Grave		Town State 2	in Code)	
<u> </u>	s 1 and 2 should if Health and Mer Item 27 le marke other treumatic		Daryl DePrenda			1									
စ်	f Hea f Hea ltem		20a. Method of Disposition	Son	20b.	Place of Dispo cemetery, crei	sition (Nan	ne of			Dickers Date		ID 208 ition - City or		
Ê	00		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State					7 6/2	29/2007	Silv	er Spr	ing, MD	
saltimore,	# 문 <b>문</b> 를 .		21. Signature of Funeral Service											uneral	Home
n	Depa Impo any l		Kyandy	Duge	~						amascus			20872	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or shock, at heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter I legislating.	a	or as a conser	DIDN quence of):			L774		п төзрпасоту а	ii est,		Approximate Interval Betw Onset and D	een
68/60,	certificate be executed nding physician and use as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):									
C. Box	the death y the atter sched for i	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ointh 2 ☐ Feta nant at time of a	aldeath 3[	Ectopic pr Other (sp					23	d. Date of deli Month	-	ear
ecords, r	w requires that been signed b should be dete	þ	Part II. Other significant condition  AMY LO	ns contributing to d	eath but not re	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did t			the cause of de obably 4 □Ur	nknown
r	The law ate has b pege 2 sl	Completed	MULTI	PLE.	MYE	LON	nA				24a. Was autor perfo		24b. Were au prior to death? 1 🗆 Yes	topsy findings a completion of cal	vailable use of
Vital	ysician: is certific director.	Be	25. Was case referred to medical examiner?					1		of Death	(Check only o	ne)			
6	Physi this c	2	1 ☐ Yes 2 No			ER/Outpatier			4 🗀 (4u		ne 5 DiRes⊪			cify)	
	ding F P. After funer	lon	27. Manner of Death  1 ⚠ Natural 5 ☐ Pendin	9	of Injury th, Day Year)	28b. Time o Injury		8c. Injun Worl			28d. Describe l	how injury	occurred		
<u> </u>	death ctor: / the	Icat	2 Accident investig 3 Suicide 6 Could r	not be 290 Bloom	of Injury - At h	nome form clr	M factor		Yes 2 □ I		28f Location (	Stroot and	Number or P	ral Route Numb	10.5
UIVISION	l or Attending Physician: after death. Director: After this certifica i in by the funeral director.	ertification:	4 ☐ Homicide determ	ined buildi	ng, etc. (Speci	fy)	eet, lactory	, onice		1	City or To		vuiliber of AL	rai Aoule Ivullo	97,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the b and man	best of my knoasis of examination	owledge, deatl ation and/or in	occurred vestigation,	at the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)	
	within To th compl	Me	29b. Signature and litle of certifier	1			290	. License	e number			29d. Date	signed (Monti	n, Day, Year)	
			Marlen	e J. Ha	uma	an 1	us	7	) 31	36	2		e 26,		
1	0/		30. Name and address of person	who completed caus	e dideath (Ite	m 23a) (Type,	Print) F	n Al	ERSI	BUI	T. HA				
d	Sta Registr		31. Date filed (Month, Day, Year)	7 2007 32.	gistrar's Sign	ature A	north	,			,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 06/22/2007Denoff Lewis Deno 9:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Spa Creek Center Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1**X** M 2 □ F 07/12/1930 Ψĭrginia Director 236-46-2505 76 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director VA Fairfax Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 22180 106 Tapawingo Road S.E. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates: Specify 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Katz Car Radio Electronic Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Denoff Nannie Laferty ဥ Chriss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Muscatello/Dau. 224 West Lake Dr, Annapolis, MD, 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Natl.Memorial Park 6/26/2007 Falls Church, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signatur 7482 Lee Hwy.22042 Funeral Home, Falls Church, VA National 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Finai tamia Physician disease or condition resulting in death) /Medical Due to (or as a coneuence of) Examiner Sequentially list conditions, Tue to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Year Dav 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably **#** □Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy performe Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 3 ☐ DOA 1 Inpatient 2 ☐ ER/Outpatient မ funeral within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) certifier 29b. Signature and 14

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 6 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave Annapolis

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 6:41p M 24,2007 June Daniel Lee Everett /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 Union Hospital E1kton Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 **X**M 2 □ F 218-70-3864 49 20,1957 November Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director MD Ceci1 North East 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 18 Rolling Mill Lane 21901 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marina Boat Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ira Everett Mary Bell Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Rolling Mill Lane, North East, MD Beverly Everett/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 28,2007 Elkton, MD 4 Donation 5 Other (Specify) Elkton Cemetery 21. Signature of Foneral service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD shock, or hear failure. List only one cause on each line. 21021 or o i ate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical lo (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 28d. Describe how injury occurred Certification:

Examiner death certificate be executed and burial-trar ed by the attending physician detached for use as the buria P.O. Box 68760 signed by to Division or Vital Records, page 2 should certificate funeral director this

28a-f show

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

within 72 hours after

es 1 and 2 should be fill of Health and Mental H

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot

Baltimore, Maryland 21215-0036

28b. Time of

Manner of Death 1 Natural 2 Accident

5 ☐ Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D00060756 29d. Date signed (Month, Day, Year) 6 26 260 7

State

31. Date filed (Month, Day, Year)

30. Name and address of person

JUN 2

Wo completed cause of death (Item 23a) (Type, Print) was completed cause of death (Item 23a) (Type, Print) was main St. Elkho, MD eden Coksaygan, ND 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aff

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month 06 Day 21 **Physician** 2007 Jean Gill 9:50 a M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LaPlata CHARLES Genesis Health Care if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min NEW JERSEY 1 □ M 🗶🕱 F 04, Yrs DEC. 81 Director 577 32 6766 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he norified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1XXYes 2 □ No Director CHARLES LA PLATA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 1 MAGNOLIA DRIVE 20646 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No if Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify: BLACK ģ 3 Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE COSMETOLOGIST 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARIE GARRISON ROBERT SIMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WALDORF, MD 20603 RAYNELL KING / DAUGHTER 2463 KENBROOK CT. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 □Cremation 3 □Removal from State FORT LINCOLN CEMETERY 06/27/2007 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattshatte's Fanetat Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EARI uns ONGRITTIR **Physician** /Medical Due to (or as a consequence of): Examiner THERWICE ANANCINO. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi and Due to (or as a consequence of). Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I ned by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s 2 No 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Loursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 1. Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Registrar

7

29b. Signard and title of certifier

and manner stated

who completed cause of death (Item 23a) (Type, Rrint)

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DZ0629

29d. Date signed (Month, Pay, Year)

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Privitin 24 hours after death.

To the Funeral Director; After the completely filled in by the funera

Immediate Cause (Final disease or condition resulting in death)	a MYOCARDIAL IN	FARCTION	Onset and Death
resulting in dealth)	Due to (or as a consequence of):		
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to or as a consequence of :		
that initiated events resulting in death) Last	C		
	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregna 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause $\mathcal{U} \circ \mathcal{A}$		use contribute to the cause of death?  2 No 3 Probably 4 Munknown
		24a. Was an autopsy performed? 1 □ Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Death Check only one)	
	Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5 Residence	6 □Other (Specify)
27. Martner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		njury at Vork? □ Yes 2 □ No	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier (Check only one) 1 Certifying Phy one) 2 Medical Exam	visician: To the best of my knowledge, death occurred at the iner: On the basis of examination and/or investigation, in m and manner stated.	time, date and place, and due to the cause( y opinion, death occurred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	29c. Lice	ense number 29d. D	ate signed (Month, Day, Year)

400 Eastern Shore Dr., Salisbury, MD 21804

DHMH 17 Rev 1/2001

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Rene Desmarais Jr.

	State of Maryland / Dep	artment of Health and Nartificate of Death		
Physician	1. Decedent's Name (First, Middle, Last)  Margaret C. Grambo	Timodio of Bodin	2. Date of Death Month June 22, 200	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  109 Rockdale Drive	4b. City, Town, or Location of Death Silver Spring		Death
Funeral Director	5. Social Security Number  579-12-1092  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 7 yrs.	Months Days Hours Min.	(Month, Day, Year)	Birthplace (State or Foreign Country) ashington, DC
e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 3e Completed by Funeral Director	10a. State 10b. County 10c. City, Town or L MD Montgomery Silver  10e. Street and Number 109 Rockdale Drive		10g. Citizen of What USA  Decify Yes or No- Discan, etc.)  10g. Citizen of What USA  14. Race - Black, N	10d. Inside City Limits 1 □ Yes 2 No  It Country?  American Indian, White, etc.
ed within 72 hours af ygiene. Ier than "natural", or t, the Medical Exam Completed by I	3 🗷 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	1 □ Yes 2 ▼ No Specify:  edent's Usual Occupation e kind of work done during most of work DO NOT use retired)  emaker	16b. Kind of Busin	·
2 should be file and Mental Hy, Is marked othe raumatic event, To Be C	17. Father's Name (First, Middle, Last)  George Joseph Cleary		e (First, Middle, Maiden Surname) ertrude McKernan	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Francis F. Grambo, Jr. / Son 325 C  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	ematory or other place)	Forest Hill, MD Date 20c. Location - Cit /26/2007 Silver	21050 y or Town, State Spring, MD
cate be executed by Sician and the burial-transit the burial-transit dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	erstite mode of dying, such as cardiac		Approximate Interval Between Onset and Death
w requires that the death certific been signed by the attending p should be detached for use as i should by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date o	
requires that the een signed by the nould be detache steed by Phys.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		ite to the cause of death?  ☐ Probably 4 ☐ Unknown
The larate has page 2			autopsy prio performed? dea 1∐ Yes 2 → Ho 1 □	re autopsy findings available or to completion of cause of tth? Yes 2 \( \text{No} \)
o the Hospital or Attending Physician: Ithin 24 hours after death. o the Funeral Director: After this certific ompletely filled in by the funeral director, Medical Certification: To Be (	25. Was case referred to medical examiner?  1	ent 3 DOA Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No	th (Check only one) ome 5 Presidence 6 Other 28d. Describe how injury occurred  28f. Location (Street and Number City or Town, State)	
he Hospital of in 24 hours af he Funeral Dipletely filled in period of the funeral Celedical Cel	29a. Certifier  (Check only one)  1X Certifying Physician: To the best of my knowledge, deal of examination and/or and manner stated.			
To the Hos within 24 hu To the Fun completely completely Medica	29b. Signature and title of certifier  P 7 9 6 and mainler stated.  29b. Name and address of person who completed cause of death (Item 23a) (Type	1 0 0 0 7 7	29d. Date signed (/	Month, Day, Year)
State Registrar	Ata Motamedi 18111 Prince Phillip  31. Date filed (Month, Day, Year)  11. 2 6 2007		32	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 3:39 PM M Louis Hook 2007 June 16. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1223 Silverthorne Road Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director Yrs. April 11 1930 Baltimore, Maryland 218 26 5781 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show ir then "naturel", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at Director Maryland Baltimore City 1 ☑ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239-3434 1223 Silverthorne Road USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. MXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced W TT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) NA Elementary/Secondary (0-12) Bethlehem Steel Mill Wright 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ပ Samuel Hook Katherine Martinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 le eny Injury or other trau once. 1223 Silverthorne Road Baltimore, Maryland 21239-3434 Nancy L. Hook 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc July 3 2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OVON AR. /Medical Examiner HEYO SCEE ROSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death signed by the aid be detached for 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown been si should I 1 TYes 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 certificate 1 Tes 2 No or Attending Physicien: To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Tyes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) timore, mi h Raven 31. Date filed (Month, Day, Year) negistrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June **Physician** 200 John Samuel Hart /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days **™** M 2□ F 79 Director 213-24-3354 9. 1928 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Funeral Director Maryland Charles Indian Head 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i 6404 Chicamuxen Road 20640 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Joseph M. Hart Mamie Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James A. Monroe Son 6404 Chicamuxen Rd., Indian Head, Md. 20640 of Health permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) June 26, 2006 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Charles Cemetery Indian Head, Maryland 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funera M00668 4270 HAwthorne Rd., Indian Head, Md. 20640 23a. Part1. Enter the dise ase, or complications that caused the death. Do not offer the mode of dying, such as cardiac or respiratory arrest, at List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a con squence of) Examiner Osquentiary list exhibitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner lower exhemetres allers burial-trar Due to (or a attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 ☐ Yes P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide

law requires that the death certificate be executed Box 68760. P.O. Records, Division or Vital Hospital or Attending Physician: death. after ( the Funeral D hours a 24

with the Maryland

72 hours after

filed within

1 and 2 should be

Maryland

3altimore,

State Registrar

Medical

29a. Certifier

29b. Signature and title of ce

Abbas Omais, m.D. JUN 2 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Fegistrar's Signature

Post Office Rd. Waldor 7-C

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year William L. Hyatt Αм June 22 2007 7:10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Catonsville Baltimore Charlestown Retirement Community If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Hours Months NOW 2□ F 92 July 5, 1914 214-05-0713 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore Catonsville 1 ☐ Yes 2 No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 U.S.A. 719 Maiden Choice Lane, BR 125 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 1942–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 X No Specify: Specify: 3℃Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supply and Fiscal Dept. U.S. Naval Academy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Hanna John H. Hyatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 664 Kensington Avenue Severna Park, Maryland 21146 Barbara H, Day/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 6/25/2007 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Juneral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OFUNAI Due to (or as a consequence of) Sequentially list conditions, the bong It immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 ☐ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the death certificate be executed and -tran: attending physician a I for use as the burial-Division or Vital Records, P.O. Box 68760, signed by the a Id be detached f has e 2 Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag

**Physician** 

/Medical

**Examiner** 

**Funeral Director** 

Be Completed by

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

permit. Pages Department of Important: If it any Injury or or

Physician /Medical

Examiner

Examiner

Physician/Medical

Completed

Be

P

Certification:

Medical the State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

WND

( are

2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

June 22, 2007

Catursville

Name and address of Jerson was completed cause of death (Item 23a) (Type, Print) 15 0 Maide Charl

5 2007

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Horner 2.3 07 onald /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomica at the Hospice Lake If Under 1 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Funeral 1**∑**M 2□F 69 Director 10/15/1937 Maryland 218-34-8864 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

arked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Wicomico Quantico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25090 Nanticoke Road 21856 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry traumatic event, the Medical Give kind of work done during most of working life. DO NOT use retired) Wicomico County Board of Education College (1-4or 5+) Elementary/Secondary (0-12) electrician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Menta permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic events. Dora Webster James Horner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Horner/wife 25090 Nanticoke Rd., Quantico, MD 21856 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 6/26/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 22. Name and Address of Facility Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Chompson Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NROPLASM OF PANCREAS Physician MALIGNANT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events and burial-trar resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 22 No page 2 25. Was case referred to medical examiner?
1 Yes 2 No director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Minpatient Certification: To this 28b. Time of 27. Manner of Death 28a Date of Injury 28c. Injury at Work? 28d Describe how injury occurred (Month, Day Year) To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral Direct completely filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 00052410 Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPICA P.O BOX #1733 SAUSBURY MY 21802 WARIS DASTAL GHULAM

Registrar

31. Date filed (Month, Day, Year)

JUN 2 6 2007

Begistrar's Signature

		For State Registrar		Cer	tificate o	Death		Reg. No. 2	007	22291
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Virginia M.	Hopkins				2. Date of De Month	Day	Year 2007	3. Time of Death  08!48 AM
Examin	2.	4a. Eacility Name (If not institution, give street ENINSULA KEGION AC	A/2	ENTER	SALI.	or Location of Deatl	1	1 / /	ty of Death	٥
uneral irector		213-12-0402	7. Age (In yrs	: last birthday) Yrs.	If Under 1 Year Months Day	r If Under 24 Hrs. s Hours Min.	8. Date of Bi (Month, Di	ay, Year)	Coun	lace (State or Foreign try) ginia
be notified at		Usual Residence of Decedent  10a. State 10b. County		ity, Town or Loc					1	0d. Inside City Limits
Currey	Director	Maryland Wicomico		Salisbu	ry 10f. Zip Code			10g. Citizen o	of What Coun	1 □ Yes 2 □ No
	Ē	1114 E. Church St.			2180			USA		,
	by Funeral		. Was Decedent Ever in the Armed Forces?  Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specity Co □ Yes 2🛛 N	Hispanic Origin? (Suban, Mexican, Puerloo Specify:	pecify Yes or N to Rican, etc.)	0- 14. R B	ace - Americ lack, White, cify: wh	
1	Completed to	15. Decedent's Educa (Specify only highest grade of		16a. Deced (Give) life. D	lent's Usual Occ kind of work dor OO NOT use reti	upation e during most of wor red)	rking	16b. Kind of	Business/Ind	dustry
	Com	8		Sale	s				er com	pany
	Be	17. Father's Name ( <i>First, Middle, Last</i> ) <b>Estle E. Jones</b>				18. Mother's Nar	ne <i>(First, Middle</i> che Ell:		ame)	
	Ը	19a. Informant's Name/Relationship (Type Lana Wilkerson/dau				et and Number or Ri g Lane, Wo				
		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Rer	20b.	Place of Dispos		-	Date		n - City or To	
		4 ☐ Donation 5 ☐ Other (Specify)		Gardens		6/2	6/07		on, MD	
	0	10-09/10	MODORO CAS	e   H	olloway 01 Snow	Funerál Hill Rd.	Home Pro , Salis	ofessio oury, M	nal As D 2180	sociation 4
for use as the burial-transit	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a conse	PD equence of):						
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 [☑ No 9 □ Unknown	. If yes, outcome pf preg 1 □Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3□	]Ectopic pregna ]Other <i>(specify)</i>				Date of delive	ery Day Year
	by	Part II. Other significant conditions contr	ibuting to death but not re	esulting in the ur	nderlying cause	given in Part I.		tobacco use co ]Yes 2 □ No		ne cause of death?
	Completed						per 1∐ Yes	opsy formed? 2 No	b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 \square No
ullector, page 2 s	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1  □ Inpatient 2[	☐ ER/Outpatien	nt 3 DOA	26. Place of De			ther (Specif	y Ambulan
	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of	f 28c. Ir	ijury at /ork? □ Yes 2 □ No	1	how injury occ		7777
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spec		eet, factory, offic	ce		(Street and Nu own, State)	mber or Rura	al Route Number,
completely filled in by the funeral	Medical		cian: To the best of my ki er: On the basis of exami and manner stated.					e, date and plac	e, and due t	o the cause(s)
(	Ź	29b. Signature and title of certifier  Daa M. D				9795 2	_	29d. Date sig		
N.	I	30. Name and address of person who com		00 \ (75						

DHMH 17 Rev 1/2001

ORIGINAL.

			For State of Maryland / Depar   - State of Maryland / Depar   Certi	tment of Health an <i>ficate of Death</i>	•	giene Reg. No. 2000	7 0000
			Decedent's Name (First, Middle, Last)		2. Date of De	ath	3. Time of Death
-	Physicia /Medic		Dale, E. Jones		noth 2	6 ZOO7	1518 M
Sec.	Examin		4a. Facility Name (If not institution, give street and number)	b. City, Town, or Location of D		4c. County of Dea	th
			Coastal Hospice at the Lake	Salisbur		Wicom	1100
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Min. (Month, Da	th 9. Birt	tholace (State or Foreign
в	Director		219-44-1435   Marie   61   Yrs.		8/18/1	945	ountry) MD
	and .		Usual Residence of Decedent         10c. City, Town or Loca           10a, State         10b. County         10c. City, Town or Loca	tion			10d, Inside City Limits
	fanylarylarylarylarylarylarylarylarylarylar	ō					1 ☐ Yes 2 🔯 No
	the N 28a-	Director	MD Worcester Berlin  10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	with tagor	Ö	Decatur Apts. Unit 504	21811		USA	
	ns 2: mus	Funeral		is Decedent of Hispanic Origin es, specify Cuban, Mexican, P	? (Specify Yes or No		
10	ifter or iter	교	1 ☐ Never Married 2 ☐ Married 1 ☐ XYes 2 ☐ No		uerto Rican, etc.)		
5-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Moivorced   If Yes, Give Year or Dates:	Yes 2 No Specify:		Specify: Wh	ite
5-0	72 ho natur lical	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir.	nt's Usual Occupation and of work done during most of	working	16b. Kind of Business	/Industry
2	ithin he.	훁	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)	working		
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Ē	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last)	ı	Name (First, Middle,	, Maiden Surname)	
3	should ind Men is marke umatic	유	Charles Thomas Jones		h Cathell		
Maryland	d 2 st th and 7 is n traun			Address <i>(Street and Number o</i> Adkins Rd., Be			Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Achsah Jarmon/sister 10805		Date Date	20c. Location - City or	Town State
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troope.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crema	tory or other place)	100 10007		
臣	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify) Taylorvill 21. Size un Fund Service Licensee 22. N	e Cemetery   6	/29/2007	Berlin, M	
Ba	permit. Departr Importa any inj		- W	08 William St.		_	Home
			23a. Part1. Enter the disease or complications of a caused the death. Do not enter shock, or heart failure. List only one carse on each line.		·		Approximate
No.	Physician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	Carer			
	Examiner			)			
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Ungerlying.  Due to (or as a consequence of):				
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ő	e exe ian a unal-l	Ä	resulting in death) Last  Due to (or as a consequence of):				
68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical	d				
	ertific ding p	Me	IF FEMALE:				
Box	leath certif attending for use as	ian/		ctopic pregnancy		23d. Date of de Month	livery Day Year
Ö	the de	Physician/M	1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 5 □ C	Other (specify)			
Δ.	res that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Records,	uires I sign Id be	d by			124	, Yes 2∐No 3∐P	robably 4 Unknown
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æ	he law e has l ige 2 s	m d			— auto	psy prior to death?	completion of cause of
or Vital			25. Was case referred to medical	26 Place of	1 Yes Death (Check only of	No 1 □ Yes	3 2000
Ş		To Be	examiner?  1 Yes 2 Pao Hospital: 1 Inpatient 2 ER/Outpatient	044		dence 6 ☐Other (Spe	ocifu)
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Division	Attending r death. ector: After	Certification:	Accident investigation	M 1 Yes 2 No			
Vis	r Atte	tific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (	Street and Number or R	ural Route Number,
	itaio rs aft raiDi led in	Cer			1		
	To the Hospital or Attending Phy: within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	cal	29a. Certifier  (Check only  Medical Examiner: On the basis of examination and/or inve	ccurred at the time, date and patigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner a	s stated. e to the cause(s)
	the hin 24the from the from the from the from Taplet	Medical	and manner stated.	29c. License number			
	7 wiii		29b. Signature and title of certifier	29C. License number	76	29d. Date signed (Mont	(n, Day, Year)
			pt ceepw	NYGY	18	6-11-0	
0	341		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	nt)	,1727	Solul	m 2/862
	Sta	te	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	THE 1 - DUY	(/ '))	00/10/2)	NAM CA
	Registr		JUN 2 7 2007 Beau & Spe	de			
			7				

State of Maryland / Department of Health and Mental Hygiene Amend #20b per FH 06-27-2007 CNM 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE 20007 FRANCES NICHOLSON JONES 5:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK NORTHAMPTON MANOR FREDERICK Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2 X F Yrs APR 25 Director 215-34-4014 1921 MD 86 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or iteme 23a or 28a-f ehow emphy injury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10b. County FREDERICK FREDERICK 1 Yes 2 No MD Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 USA 200 E. 16th STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WINDOW CLERK POSTAL SERVICE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY WHIPP GEORGE E. NICHOLSON မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAROLYN MAHER / NIECE 323 ADAM ROAD, FREDERICK, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/2972007 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MONOCACY CEMETERY 2/29/07 BEALLSVILLE, 22. Name and Address of Facility
HILTON FUNERAL
P.O. BOX 86, B 21. Signature of Fungral Se wice Licensee HOME BARNESVILLE, 20838 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 14605C /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 ☐ Yes ☐ Wo
9 ☐ Unit fown Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed? Mart 1 Yes 200 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 V Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes STNo 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Medical Certification; Hospital or Attending Natural 5 Pending investigation Injury efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide within 24 hours eff
To the Funeral Di
completely filled in earlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney-stated. (Check only 曹 29d. Date signed/(Month, Dey, Year) 29b. Signature and title of certifier euse of death (Item 23a) (Type, Print) who complete 30. Name and address of person 31. Date filed (Month, Day, Year) 32. Repistrar's Signature State 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 21° 2007 **Physician** Julius H. Kinlein 2:50 Рм /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City Rose Manor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 15,1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 M 2 ☐ F ΜĎ 94 Director 212 16 2929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at 1 ☐ Yes 2 No a or 28a-f sh Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 United States 23a 3209 Greenway Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐MNo f Yes, Give 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. <u>م</u> 3√2 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Construction d 2 should be filed with and Mental Hygie 7 Is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Plantholt Julius A. Kinlein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10075 Green Clover Drive Ellicott City, MD 21042 Eleanor K. Walton/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gard: 6-26-2007 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it are a list conditions, it are a list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a detached f P.O. 9 Unknown 9 ☐ Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 【★No 24a. Was an performe 1∐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: $4\square$ Nursing Home $5\square$ Residence 6 $\square$ Other (Specify ASST. 1ivg. 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA P 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification:

Division or Vital Records, or Attending Physician: funeral director. After this

within 24 hours after death To the Funeral Director; filled in by Hospital

10700 CHANTER 31. Date filed (Month, Day, Year) 2007

and manner stated.

5 ☐ Pending investigation

6 Could not be determined

JUN 2 2

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signalure

Medical

State

Registrar

4 ☐ Homicide

(Check only one)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

June 22, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

2007

#### 07-04728 Larry Stephen Lowe

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

, , , , , , , , , , , , , , , , , , , ,		1- For State Criticate of Death Registrar Certificate of Death	Reg	. No.	7 999		
Physici	an/	Decedent's Name (First, Middle,Last)		Day Year	3. Time of Death 0718 hrs		
Aedical Exami		Larry Stephen Lowe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	June 21, 20	4c. County of Death			
		4431 Prancing Deer Drive Ellicott City	uii	Howard			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24I			hplace (State or		
Director		543-40-9822 1xm 2 F 66 Yrs.	<sup>din.</sup> 07/02/1	07/02/1940 Foreign Country) ND			
aux		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
. §	5	MD Howard Ellicott City			1 Yes 2 X No		
Maryla 28a-f d at o	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cour	ntry?		
th the Maryland 23a or 28a-f sho notified at once.		4431 Prancing Deer Drive 21043		United St			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shr natic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		White, etc.	can Indian, Black,		
offer de	by Ft	1 X Yes 2 No   No   No   No   No   No   No   No		Specify: Wh	ite		
nours a		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business/I	ndustry		
9036 within 72 liene. rer than "1	Completed	Elementary/Secondary (0-12)   College (1-4 or 5+)   Professor	,	College			
21215-0036 and be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	ĕ		me (First, Middle, Ma				
21215 21215 buld be file Mental H marked of	Be	Adrian Lowe Norma	G. Mathi	son			
21 should nd Me is ma atic ev	은	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number					
, MD and 2 sho cealth and em 27 is		Dana R. Lowe/Wife 4431 Prancing Deer  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City or			
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental fant: If item 27 is marked or other traumatic event,		Burial 2 X Cremation 3 Removal from State crematory or other place)	-22-2007	Catonsvil	I o Ma		
Baltimore, MD 2: permit. Pages I and 2 should Department of Health and M Important: If item 27 is minjury or other traumatic e		Donation 5 Other Specify: Metro Crematory 6  Signature of Funeral Service Licensee M01044 22. Name and Address of FacilityHa					
Dep Dep B		Hum Collis - Utlah 4112 Old Columbia	Pike Ell	icott City	, MD 21043		
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and		
Examiner	8.	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):			Death		
		Sequentially list conditions,  b					
	niner	if any, leading to immediate cause. Enter Underlying Cause					
ted 1 insit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.					
760, icate be executed s physician and the burial - transit	Medical	UNPENDED AMENDED					
760, ficate b g physic the bu		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	anana.	23d. Date of delivery			
Box 687 e death certific the attending p	Physician/	past 12 months?  4 Pregnant at time of death  5 Other (Specify)	griancy	Month [	Day Year		
Boyne death	hys	1 Yes 2 No 9 Unknown g Unknown	00 - Did t-b	acco use contribute to	Ab a course of death 2		
P.O.	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		2 No 3 Prot			
ords, P.C. w requires that as been signed be should be deta	eted		24a. Was ar		topsy findings available		
e law ie has te ge 2 sh	Completed		autops perform 1 Yes 2	ned? death?	completion of cause of es 2 No		
tal Rec		25. Was case referred to medical 26.Place of Death (Che		1 10	2 110		
Vita hysicis this ce	o Be	examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nu	rsing Home 5 F	Residence 6 🗸 Othe	r: Scene		
1 of Iing P After funera	L:uo	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred			
ivision or Attene after death Director:	icati	2 Accident Investigation 28e Place of Injury - 4t home farm street factory office building etc.	28f Location (St	reet and Number or Ru	ıral Route Number, City		
Divis Hospital or A 24 hours after Funeral Dire	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, Sta				
Divisi To the Hospital or Att within 24 hours after d Fo the Funeral Direct completely filled in by		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred					
	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	nth, Day, Year)		
10+		Carde Hallan O.C.M.E.		June 21, 2007			
E.G.		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201				
	tate	31. Date filed (Month, Day Year) 32. Reustrar's Signature	201				
Regis	trar	JUN 2 2 2007 Bleeve & Sparks					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 0425 M Layfield Townsend 2007 Katherine /Medical 4c. County of Death 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ALISBURY NICOMICO MEDICAL CENTER PENINSULA EGIVARL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗙 F 86 Maryland 4/17/1921 Director 216-14-2309 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Parsonsburg Director Maryland Wicomico 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21849 33382 Middleton Rd. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 🔀 No 3altimore, Maryland 21215-0036 Specify: white Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Retail Food Cashier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Adams Murray E. Townsend ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5856 Killens Pond Rd., Felton, DE 19943 Janice Winkler/daughter Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/25/07 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Park Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due o (or as a consequence of): ays disease or condition resulting in death) /Medical Examiner clostridium difficile Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed c. my elo dys plastic.

Due to (or as a consequence of): burial-tran Division or Vital Records, P.O. Box 68760, physician s the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an protein mal death? 1 □ Yes certificate 2 📝 2 No cerebral Vascular 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[] No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

To the Hospital or Attending Physician: within 24 hours a

To the Funeral I

completely filled

31. Date filed (Month, Day, Year)

Jaleli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

(Check only one)

S. Keza



State Registrar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0060715

, md

29d. Date signed (Month, Day, Year)

June 22

2007

			101	partment of Health and Menta	al Hygiene
			Decedent's Name (First, Middle, Last)		te of Death 3. Time of Death
	Physicia /Medic		Edna Louise Massey		onth 25, 2007   8:17 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Ft. Washington Hospital	Ft. Washington	Prince George's
	Funeral Director		5. Social Security Number  6. Sex  1 M 2 X F  7. Age (In yrs. last birthday  78  Yrs.	/ If Under 1 Year If Under 24 Hrs. 8. Da Months Days Hours Min. // Min.	te of Birth 9. Birthplace (State or Foreign County)
			Usual Residence of Decedent	Jui	ne 14, 1929 Virginia
	nyiand how		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	e Ma	by Funeral Director	Maryland Charles India	an Head	12∕ Yes 2 No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23s	ral	7 Jonquil Place	20640	US
	ter de Item	in	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 N No	. Was Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican,	
99	urs af	by F	3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: White
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f show tha Medical Evarrimer must be coulted at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
2121	ithin Ben "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Charles County
	filed withi Hygiene. other than			od Service Manager	Board of Education
anc	ntal Hed of	Be	17. Father's Name (First, Middle, Last)		Middle, Maiden Sumame)
aryland	2 should land Men ls marke	ဥ	Marshall G. Cooper  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	ling Address (Street and Number or Rural Route	irginia Beach
≥	C1 60 50 60			onquil Place, Indian F	
re,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disp		20c. Location - City or Town, State
ltimore,	Pages nent of int: If it			Mem. Mausoleum 6-28-0	77 Waldorf, MD
Balti	permit. Pages Department of Important: If it any injury or once.				035 Old Washington Road aldorf, MD 20601
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.		
4	Pnysician		Immediate Cause (Final disease or condition	Failure	Onset and Death  WN KNOWN
	/Medical Examiner		resulting in death)  Due to (or as a sonsequence of):	CI	Ll
	LAdillilei	Ļ	Sequentially list conditions, b. Arollo 9	mc Shock	
	ted 1sit	Examiner	if any, feuding to immediate cause. Enter Underlying Cause (Disease or injury	SI W	ч
	be executed sicien and burial-transit	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):	3400	
8760	certificate be executed iding physicien and ise as the burial-transit	dicai E	d		
9	tificate ng phys as the	Medi			
Box		Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery
0.	the dea by the at tached fo	sici	in the past 12 months?  1   Yes 2   No	Other (specify)	Month Day Year
<u>.</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I 23	Be. Did tobacco use contribute to the cause of death?
ecords,	es De pe	d by	LENKEMIA	and onlying outdoor grown in any i.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown
ဂွဲ	w requir	iete	Chronic Obstructive Pul	HONA DEC DEC 24	a. Was an 24b. Were autopsy findings available
ě	0 - 0	Completed	SPINAL STENOSIS		autopsy prior to completion of cause of performed? death?
Vital H	ician: Th	a	25. Was case referred to medical	26. Place of Death (Chec	Yes 2 No 1 Yes 2 No
	y S	To B	examiner? 1   Yes   2   No   Hospital: 1   atient 2   ER/Outpatie	0.4	Residence 6 Other (Specify)
0	ng Ph fter th neral		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury		escribe how injury occurred
<u>0</u>	Attending ir death. ector: After by the fune	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
UIVISION	al or Attend after death Director: d in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		cation (Street and Number or Rural Route Number, y or Town, State)
_	D D D D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and dur	a to the equat(a) and manner as stated
	는 무 다 가 는 이 이 이 이 이 이 이 이 이 이 이 이 이 이 이 이 이 이	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	rvestigation, in my opinion, death occurred at the	ne time, date and place, and due to the cause(s)
	To the within 2 To the Complet	₩ We	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		- 1	Janle Klo	DO0 26262	· 06/25/2007
9			30. Name and address of person who completed cause of death (Item 23a) (Type	•	
	NB4		Samuel Kleiman, MD, 11711 Livingston	Road, Ft. Washington	, MD 20744
	Star Registra	te ar		Road, Ft. Washington	, MD 20744

1-

Be Completed by Funeral Director

일

Physician /Medical

Examiner

Funeral

Director

For State		Co	rtificate of	lealth and l Death	,		1007	2022
Registrar . Decedent's Name (First, Middle, L	ast)	Cei	i illicale Ul	Dealli	2. Date of De	Reg. No.		3. Time of Death
	ueller				June	22,	2007	10:30A M
. Facility Name (If not institution, ga			4b. City, Town, o	r Location of Death	1	4c. C	County of Death	
La Plata Center			La P				Charles	
	Sex 7. Ag 1 ☐ M 2 🕅 F	je (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da August	av Voari	Carin	lace (State or Foreign try)
213-38-4814		66			August	. 10,1	J40 NC	
a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
MD Charl	es	Welc	come					1 ☐ Yes 2Ã No
e. Street and Number			10f. Zip Code			10g. Citiz	en of What Coun	try?
7005 Henson Land	_,		2069			ŲŞ		on Indias
Marital Status	12. Was Decedent	,	Was Decedent of F If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No to Rican, etc.)	0- 1	4. Race - Americ Black, White,	
1 ☐ Never Married <b>2</b> ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	INO	1 ☐ Yes 2 ☐ XNo	Specify:			Specify: Wh:	ite
15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation	adeim a	16b. Kin	d of Business/Ind	dustry
(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4or	life.	kind of work done DO NOT use retire	d)	rking		**	
12			Homemake				Home	
Father's Name ( <i>First, Middle, La</i>	st)			18. Mother's Nan	, ,		surname)	
Ted Livesay	(Time Print)	406-84-10	ing Address (Street		Livesa		Town State 7:-	Code)
9a. Informant's Name/Relationship	,		5 Henson					
Gene Mueller/Hus  a. Method of Disposition	sband	20b. Place of Dispo cemetery, cre			Date		ation - City or To	
1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State			1	26/07	77-7-1	. 6. 34	
Signature of Fuheral Service Lic		0945 2	2. Name and Addre	ess of Facility			orf,Mary	Land
1 Aguilla	E.h.S	A	REHART-EC				7/16/	6
3a. Part1. Enter the disease, or co	mplications that cause	d the death. Do not en	11 St. No. iter the mode of dyi	ng, such as cardia	c or respiratory	ata,M	2.004	Approximate
shock, or heart failure. List on mmediate Cause (Final	ly one cause on each I	ine.	A1 7 14	DI 40 96	10 00	Cn.		Interval Between Onset and Death
sease or condition sulting in death)	a.	a consequence of):	172211	217119	191	16.		
		η			- 6			
equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury	Due to (or as	a consequence of):						
at initiated events	С.							
sulting in death) Last	Due to (or as	a consequence of):						
	d							
FEMALE:								
3b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3	□Ectopic pregnanc	y		2	3d. Date of delive Month	ery Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9∐Unknown	t time of death 5	Other (specify) _					
art II. Other significant conditions	contributing to death	out not resulting in the I	ınderiving cause gi	ven in Part I	23e, Did	tobacco us	se contribute to the	ne cause of death?
1421 P125	FENSIA	<u>۸</u>					]No 3☐ Prob	$\sim$
7	EDZ, M	2c1 try						
D1096	11/2 //	101117		<del> </del>	24a. Wa: auto peri	s an opsy formed?	24b. Were auto prior to co death?	psy findings available mpletion of cause of
					1□ Yes	2 No	1 Yes	2□ No
Was case referred to medical examiner?	Hospital:		ot all post Ot	nor:	ath (Check only			
1 ☐ Yes 2X ☐ No . Mapner of Death	1 ☐ Inpat		ant 3 DOA	4 A I Nursing F	Home 5 ☐ Res 28d. Describe		Other (Special	y)
1 Anatural 5 Pending	(Month, D		Wo	rk? ]Yes 2∐No				
3 Suicide 6 Could not	be 28e. Place of in	jury - At home, farm, st						al Route Number,
4 ☐ Homicide determine	building, e	tc. (Specify)	-			òwn, State)		
9a. Certifier 1 ← Certifying (Check only 2 ← Medical Ex	aminer: On the basis	t of my knowledge, dea of examination and/or i	th occurred at the t	ime, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) e, date and	and manner as s place, and due t	stated. o the cause(s)
one)	and manner s	tated.						
one) 29b. Signature and title of continuous	and manner s	tated.	29c. Licen	se number		29d. Date	e signed (Month,	Day, Year)

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

MEINDERS 31. Date filed (Month, Day, Year)

JUN 2 6

30. Name and address of pe

MD

2007

son who completed cause of death (Item 23a) (Type, Print)

32. Pajistrar's Signature

12070

0-021NZ COZ 12100

20602

MAZPOLF

			For State Registrar	te of Maryland / Dep Ce	partment of H ertificate of I			iene eg. No. 2 A A T	00000
	Physici		1. Decedent's Name (First, Middle, Last)  PAUI BEN	MAY5			2. Date of Deal Month JUNE	Day Year 21 2007	3. Time of Death 10:08 PM
	/Medic Examin	-	4a. Facility Name (If not institution, give street a FUTURE CARE PINE		4b. City, Town, or CLINT	Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 A 2	7. Age (In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 1	9. Birth 909 GEO	hplace (State or Foreign untry) RGIA
	e Maryland a-f show iffied at	ctor	Usual Residence of Decedent  10a. State 10b. County  DC	10c. City, Town or I					10d. Inside City Limits 1
	with the	Director	10e. Street and Number 4206 EADS STREET N.	F.	10f. Zip Code 2001	9	1	0g. Citizen of What Co	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 15		B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 █ਔNo		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
21215-0036	d within 72 hou giene. Ir than "natur. the Medical E	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Co 1 2 t h	leted) (Giv life lege (1-4or 5+)	edent's Usual Occup re kind of work done of DO NOT use retired TRACTOR	during most of work	ing	16b. Kind of Business/l	Industry
Maryland	uld be filed Mental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) OWENS MAYS			18. Mother's Name		Maiden Surname)	
Mary	d 2 should th and Mer 7 is marke traumatic	_	19a. Informant's Name/Relationship (Type. Pri					r, City or Town, State, 2	
Baltimore,	Pages 1 and 2 nent of Health ant: If Item 27 in y or other tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	20b. Place of Disconnectory, city QUANTICO	position (Name of rematory or other place)  NATIONAL	ce) 07-2	Date2007	20c. Location - City or TRIANGLE, V	Town, State
Balt	permit. Departr Importa any injt	: 50	21. Signature of Funeral Service Licensee		22. Name and Addre			MD 20785	ME
8760,	Physician /Medical Examiner the pnial-transit the pnial-transit	dical Examiner	Sequentially list conditions, if any, leading to finine flate cause. Enter Underlying Cause (Disease or Injury that initiated events	se on each line.	GE DI			est,	Approximate Interval Between Onset and Death
O. Box 68	The law requires that the death certificate wite has been signed by the attending phy age 2 should be detached for use as the	Physician/Medic	in the past 12 months?		□ Ectopic pregnancy	,		23d. Date of deli Month	ivery Day Year
	w requires that to be some signed by should be detailed	by	Part II. Other significant conditions contribution  Hypertunson	ng to death but not resulting in the	underlying cause giv	en in Part I.		bacco use contribute to	the cause of death?
Vital Records, P.	Physician: The law req this certificate has beer al director, page 2 shou	Completed					24a. Was a autops perfor 1∐ Yes	sy prior to d	atopsy findings available completion of cause of 2 ☐ No
Z K	ysician is certifi director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospita	l: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Oth	er: 4 Nursing Ho		ence 6 □Other (Spec	cifv)
Division or \	ing l		27. Manner of Death  1 X Natural 5 □ Pending 2 □ Accident investigation	. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injur Wor			ow injury occurred	
Divis	tal or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e	. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ural Route Number,
	To the Hospital or A within 24 hours after to the Funeral Dire completely filled in b	edical	(Check only 2 Medical Examiner: O	To the best of my knowledge, de n the basis of examination and/or d manner stated.					
	To To t	Σ	29b. Signature and title of certifier		29c. Licens		2	9d. Date signed <i>(Monti</i>	
	Sta Registr	- 1	30. Name and address of person who complete  BAHKAM PISHDAD, M. 31. Date filed (Month, Day, Year)  JUN 2 7 2007		e, Print) THERY AU	r. 5E.	WAS	нгистон, I	oc, 20032

			For State	State of Marylan		ertment of F		Mental Hyg	jiene		
		_	Registrar	-4\	Cer	inicate of	Deam	2. Date of Dea	eg. No.	107	3. Time of Death
il.	Physici	an	1. Decedent's Name (First, Middle, Las					Month	Day	Year	
	/Medic	al	MICHAEL		ERCER			JUNE		007	9:40A M
18 ss	Examin	er	4a. Facility Name (If not institution, give SOUTHERN MARYI		L	4b. City, Town, o		th	PRINC:		ORGES
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		) Vear)	9. Birthp	lace (State or Foreign
152	Director		578-96-6867	2XM 2□F 40	Yrs.	Months Days	Hours Will	11/23/			INGTON, DC
	p ,		Usual Residence of Decedent	400 Cit	ty, Town or Lo	ontion					Od Inside City Limite
	aryla shov d at	-	10a. State 10b. County MD PRINCE			r HEIGH'	TS			'	0d. Inside City Limits 1X1Yes 2 ☐ No
	ne M 8a-f otifie	Director		OHOROHO DI							
	with t		10e. Street and Number	·m		10f. Zip Code	47		log. Citizen of		ury r
	sath is 23a	eral	7205 CROSS S	12. Was Decedent Ever in U	10 12 1	207		Specify Ves or No.	U.S	e - Americ	an Indian
	item item	Funeral	11. Marital Status  1 X Never Married 2  Married	Armed Forces?	13.1	f Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Bla	ck, White,	
21215-0036	filed within 72 hours after death with the Maryland Hygiene, ther than "natural", or items 23a or 28a-f show art, the Medical Examiner must be notified at	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	T⊆Yes ŽQMNo	Specify:		Specif	y: B.	LACK
ğ	2 hou atura cal E		15. Decedent's Ed	lucation	16a. Deced	lent's Usual Occup	ation	[	16b. Kind of B	usiness/Ind	dustry
215	hin 7 9. an "n Medi	ple	(Specify only highest gra	College (1-4or 5+)	life. L	kind of work done OO NOT use retired	during most of wo d)	orking			
21	d wit gien gien ar tha	Completed	12		HA	IRSTYLI	ST		COS	METO:	LOGY
b	~ - V 2	Be (	17. Father's Name (First, Middle, Last) ROBERT L. MEF	RCER			18. Mother's Na	me (First, Middle, I	Maiden Surnar IOOD	ne)	
<u>a</u>		2						313 1 1 1 1 1 1			
Maryland	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (					Rural Route Numbel			
	and lealth m 27 her tr	- 30	SHIRLEY R. WO								
altimore,	Pages 1 and nent of Healt nt; If item 2 iry or other i	. 1	20a. Method of Disposition  ↑ Burial 2 □ Cremation 3 □	memoval from State		sition (Name of natory or other place			20c. Location	•	
<u>=</u>	tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify			ILL CEM		27/07	SUITL.	•	
Bal	permit. Pag Department Important: It any Injury o	J. J	21. Signature of Funeral Service Ligen	See /	1						L SERVICES
	442		200 Parti Salar Barrana	C W WAT				RD. CAM		INGS	MD 20748 Approximate
		is 9	23a. Part1. Enter the osease, or compshock, or heart a ure. List only immediate Cause (Final	one cause on each line.	. //	- 1	g, such as called	ac or respiratory arr	est,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Chroni		eng/	10114	re			
	Examiner			Due to (or as a conseq	quence of):	Mefici	Paris	Viras	Suda	14.0	
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	quence of):	0014119	ene g	VIVas	Marc		
	uted d ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							1	
Ć,	execunarial-tra	Examiner	resulting in death) Last	Due to (or as a conseq	uence of):						
8760	cate be executed physician and the burlal-transit	dical		- d							
Ó	tifica ng ph as th	ledi									
Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	ı			ate of delive	*
	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of o		Other (specify)			M	onth	Day Year
О	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/Me	9 Unknown		he f d			00 - Didde			
Ś	res the		Part II. Other significant conditions of	ontributing to death out not res	suiting in the ur	idenying cause giv	en in Fan I.		es 2∏ No		ne cause of death?
Records,	w requir been si should	Completed by	risinnag	101111			-		es Z_ NO	3 [] FIUL	ably 4 Unknown
ပ္သ	law nasb e 2 sk	nple	phyora	Sons			-	24a. Was a autops	sy	prior to co	psy findings available npletion of cause of
		S						perfor 1∐ Yes	med? 2. 7 No	death? 1 ☐ Yes	2☐No
Vital	sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		046		eath (Check only on	ne)		
	Phys this al dir	은	1 Yes 2 100	1 Inpatient 2	ER/Outpatien 28b. Time of		4 Li Nursing	Home 5 ☐ Reside			y)
ב	ding Physician: h. After this certifica funeral director, p	ioi	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	yat k? Yes 2∐No	28d. Describe ho	ow injury occui	red	
<u> </u>	E ta E e	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ome farm str		Tes Z INO	28f. Location (Si	treet and Num	her or Bur	I Poute Number
Division or	after after d in by	Certification:	4 ☐ Homicide determined	building, etc. (Special	fy)	oct, ractory, office		City or Town	n, State)	Dei Oi Huid	i nodie Namber,
	spita ours neral		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, death	occurred at the ti	me, date and place	ce, and due to the c	cause(s) and m	anner as s	tated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Directors After this certific completely filled in by the funeral director,	edical		niner: On the basis of examina and manner stated.							
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signe	_	
	_		1 try	- my	$\bigcirc$	POC	1 /0	06 0	06-2	1-60	04
)	(2)		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print) 6/8	50x0,	1 41/2	21#	101	
			Uchech To C	) gaigbeogu	m.D	67	con 4	411, m	02	07	45
	Sta Registr		31. Date filed (Month, Day, Year)	82. Registrar's Sign	3.81				_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0625AM Kicherd W Menning 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** castal Hospice At the La Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday 8. Date of Birth 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Yea 2/17/1928 Days 1 1 M 2 □ F 79 220-20-5285 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√Yes 2 No Director MD Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 688 Hilltop Rd. 21226 should be filed within 72 hours after death very manual Hygiene.
marked other than "natural", or items 23% Funeral 12. Was Decedent Ever in U.S Armed Forces? 14, Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: WW I I 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil Health and Mental H tem 27 Is marked ott Be ပ္ Richard W. Fordice Agnes Manning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. Marian Manning / wife 688 Hilltop Rd., Baltimore, MD 21226 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 □Removal from State 4 Donation 5 Other (Specify) 6/27/ 2007 Cape Henlopen Crem. Frankford, DE 21. Signature f Funeral Service Lice 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it and because and terminated cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of Examiner the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 2/1 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be No Hospital: Other: 4 \sum Nursing Home 1 Appatient ဥ 1 ☐ Yes 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner eath 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

14111

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed

JUN 2 7

2007

31. Date filed (Month, Day,

cause of death (Item 23a) (Type,

Physician

/Medical

Examiner

**Funeral** 

Director

31. Date filed (Month, Day, Year)

**Funeral Director** 

Be Completed by

2

Physician/Medical Examiner

Certification: To Be Completed by

Medical

Physician

	e or Print in B					_	ble.
1 - For State Registrar	ate of Maryland	•	nent of F			giene Reg. No. 2	07 22305
Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Day	Year 3. Time of Death
Julia Ann Parsons	Malone				JUNE	210	2001 23:34
4a. Facility Name (If not institution, give stree		4b.	-	r Location of Death		4c. County	•
MINSULA ROGIONAL MED 5. Social Security Number 6. Sex	T. Age (In yrs. I	ast hirthdays) If I	Jnder 1 Year	Is bully If Under 24 Hrs.	8. Date of Bir		9. Birthplace (State or Foreign
212-09-4661 6. Sex		Mo	nths Days	Hours Min.	Month, Da	ay, Year)	Country) Maryland
Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location	n				10d. Inside City Limits
							1 ☐ Yes 2 ☑ No
DE Sussex  10e. Street and Number	L i	urel	of. Zip Code			10g. Citizen of V	Vhat Country?
10709 Dorthy Road			19956			U.S.A.	
11 Marital Status 12. V	vas Decedent Ever in U.S	3. 13. Was I		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		e - American Indian,
1 Never Married 2 Married 1	rmed Forces?  ☐ Yes 2 No		s, specify Cuba ∕es 2 <b>⊠</b> No	an, Mexican, Puerto Specity:	o mican, etc.)		k, White, etc.
3 X Widowed 4 ☐ Divorced	Yes, Give ear or Dates:	101	ES ZKANINO	ареспу.		Specify	WIIICE
15. Decedent's Educatio (Specify only highest grade con	n npleted)	16a. Decedent's	of work done	during most of work	king	16b. Kind of Bu	usiness/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		OT use retired	,		Nurain	100
17. Father's Name (First, Middle, Last)	J	Registe	erea M		ne (First. Middle	Nursin , Maiden Surnam	
Charles Wesley Seymo	our				, ,	Seymour	
19a. Informant's Name/Relationship (Type. F		19b. Mailing Ad	Idress (Street	and Number or Ru			
Deborah Dunn (Daug		10709 1			aurel,		
20a. Method of Disposition	20b. P	ace of Disposition emetery, cremator	(Name of	T I	Date		City or Town, State
1 🔀 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	vai from State	Stephens		1	25, 200	7 Delma	r, Delaware
21. Signature of Funeral Service Licensee	Dr.	22. Nar	me and Addre	ss of Facility	~J, 200)	Delma	-, Dolawale
Punu Shart	dewell	Shor		ral Home e Street	De1ma	ar, DE	19940
23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death)		Do not enter the	e mode of dyir	ng, such as cardiac			Approximate Interval Between Onset and Death
Sequentially list conditions, b. —	Due to (or as a consequ	ence of):					
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 101 40 4 00115640	2.100 01/1					
that initiated events c c	Due to (or as a consequ	ence of):					
d							
in the past 12 menths?	i yes, outcome pf pregna □Live birth 2 □Fetal □Pregnant at time of de □Unknown	death 3 □Ecto	opic pregnanc er <i>(specify)</i> _	у			te of delivery onth Day Year
Part II. Other significant conditions contribu	iting to death but not resu	Iting in the underly	ying cause giv	ren in Part I.			ribute to the cause of death?  3 ☐ Probably 4 ☐ Unknown
					''		
					24a. Was auto perfe 1□ Yes	ormed? _L (	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?	A-1		1 - 1	26. Place of Dea	ath (Check only	one)	
1 Yes 2 No Hospi	1 mpatient 2	· · · · · · · · · · · · · · · · · · ·	DOA Oth	4 Livuising H		idence 6 □Oth	
27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju World 1	ryat rk? Yes 2 ∐ No	28d. Describe	how injury occur	red
C T Could not be	Be. Place of injury - At ho building, etc. <i>(Specif</i> )	me, farm, street, f	factory, office		28f. Location ( City or To	(Street and Numb wn, State)	per or Rural Route Number,
29a. Certifier 1 ☐ Certifying Physicia (Check only one) 2 ☐ Medical Examiner:							
29b. Signature and title of certifier	omo		29c. Licens	e number		29d. Date signed	d (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

SACISAIN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. Muddleshow, m.o. 100 & CARROLL ST.

JUN 2 6 2007

32. Registrar's Signature

	1	For State Registrar		State of M	arylan			t of He e <i>of D</i>		/lental Hy	giene Reg. No.	17	22307
Physician	1	1. Decedent's Nam	ne (First, Middle, La	(st)	1144	INEA	UX			2. Date of De Month	Day	Year	3. Time of Death
/Medica Examine	-	-		re street and number)				1	ocation of Death	) 0/00		y of Death	eunol-
Funeral		5. Social Security 1 214-30-		<u> </u>		last birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birth	' <u> </u>
Director	}-	Usual Residence o	of Decedent							April	14 1933		ryland
Maryia -f ehow lied at		Md.	10b. County  Mont	gomery	10c. Cir	y, Town or Lo Silve		ing					10d. Inside City Limits 1 ☐ Yes 2 🕍 No
with the Mac 3a or 28a-fel	2   2	10e. Street and Nu		Blvd., W.	#1	.02	10f. Zip	Code	20902		10g. Citizen of Uni		ntry? States
be filed within 72 hours after death with the Maryland stal Hyglane. Indother than "natural", or Itema 23a or 28a-f ehow event, the Madical Examinar must be neithed at Re-Commission by Financial Director	Dy rullel		rried 2⊡ Married	12. Was Decedent Armed Forces? 1 Tyes 2 H If Yes, Give Year or Dates;	,	i	Was Deced f Yes, spec	,	panic Origin? (Sp Mexican, Puerto Specify:	ecrfy Yes or No Rican, etc.)	14. Ra Bla Speci	ick, White,	can Indian, etc. Vhite
ed within 72 houygiane.	יושופופו	(Spe	15. Decedent's Eacify only highest grandlery (0-12)	ducation	5+)	16a. Deced (Give life. L	kind of wo DO NOT us	rk done du se retir <del>e</del> d)	ion ring most of work	king	16b. Kind of B		
be filed will have the the the the the the the the the th	U		(First, Middle, Last	´			Bar	ber	8. Mother's Nam	_	, Maiden Surna		
2 should and Mer is marke sumatic			Name/Relationship (				_		Julia ad Number or Rui	al Route Numb	er, City or Town		Code)
2 95 2		Joy Mul 20a. Method of Dis		/ Daughter	20b. P	lace of Dispo	sition (Nar	ne of		nnapo±1	20c. Location		109 own, State
permit. Pages 1 am Department of Heali Important: if itam 2 eny injury or other ance.		4 Donation	5 Other (Special		- 1	emetery, cren cest Oa	k Cer	neter	y 6/2	8/07		ersbu	ırg, Md.
Permit Depar Impor eny in		21. Signature of F	funeral Service Lice	see Bark	الما	22	Name an Muri P. (		of Facility Barber ox_5038,			Mđ.	20882
		23a. Part1. Enter shock, or he Immediate Cause	art failure. List only	plications that cause one cause on each li	d the death	-	er the mod	e of dying,	such as cardiac	or respiratory a	errest,		Approximate Interval Between Qnset and Death
Physician /Medical		disease or conditi resulting in death)	ion	a. ADVAA Due to (or as		UHRO uence of):	WICC	DI.	SPASE	PULM	ONARY		ZYEARS
Examiner	5	Sequentially list of if any, leading to in cause. Enter Und Cause (Disease o	onditions, immediate lerlying	b. Due to (or as	a consequ								
ficate be executed from and is the burial-transit	Lvall	Cause (Disease o that initiated event resulting in death)	ts	cDue to (or as	a conseq	uence of):							
ficate be physicial is the burner	2		•	d									
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use as i Medical Certification: To Be Completed by Physician/Medical Certification:	yalolalikin	IF FEMALE: 23b. Was deceded in the past 12 1  Yes 2 9  Unknown	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic pr Other (sp					ate of deliv	ery Day Year
signed b	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓		ificant conditions	contributing to death b	out not resi	ufting in the ur	nderlying c	ause given	in Part I.				he cause of death?
The law requir cate has been s page 2 should	and a									24a. Was	an 24b.	Were auto	opsy findings available impletion of cause of
rufficate		25. Was case refe	erre medical						26. Place of Deal	1 Tes	ormed? 2 No	1 Yes	2 🗆 No
Physicis this cert al direct	2	examiner? 1 Yes 2		Hospital: 1 Inpatio		ER/Outpatien		A Other:	4 Mursing Ho	ome 5 Res	idence 6 🗆 Ot		fy)
i or Attending F after death. Director: After I in by the funer		1 Accident	5 Pending nvestigatio		y Year)	28b. Time of Injury	M	8c. Injury a Work? 1 🗆 Ye	at es 2 □No	28d. Describe	how injury occu	rrea	
ital or Att		3 Suicide 4 Homicide	determined	building, ei	tc."(Specify	y)				City or To	wn, State)		al Route Number,
the Hosp thin 24 hour the Fune empletely fil		29a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exa	nysician: To the best miner: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurred restigation	at the time in my opir	, date and place, nion, death occur	and due to the red at the time,	date and place	and due t	o the cause(s)
With Com		29b. Signature and	d title of certifier	1. All	1	no	L 290	License r			June		
		30. Name and add	dress of person who	completed cause of	death (Item	23a) (Type,	Print)	TOPA	nstice	INDVA	There	11110	2007 MD 21/98
State Registrar		31. Date filed (Mo.		32 registr	rar's Signa	K do	sale)	10 mar (1	1011	,,,,	11 - W	jus	1.12 410

			For State Registrar	State	of Marylar	•	artmen rtificate			ınd M		Reg. N	00	1 1	77	308
	Physicia /Medic	_	1. Decedent's Name (First, Middle, L.  Marie T. Novotny								2. Date of Month June	20,	ay 2007	Year	3. Time of 2:30	Death P M
	Examin	er	4a. Facility Name (If not institution, gl Oakcrest Village				Park	vill		_				imore		
	Funeral Director		,	Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. 95	last birthday) Yrs.	If Under Months		If Under a	Min.	8. Date of (Month, 9/28/	Day, Yea.	r)	Coun	lace (State o try) nsylva	_
2	e Maryland sa-f show tiffed at	ctor	10a. State 10b. County  MD Baltin	pre		ty, Town or Lo									0d. Inside Ci	•
	vith th	Dire	10e. Street and Number				10f. Zip					10g. C		What Coun	try?	
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The file with and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show rether traumatic event, the Medical Examiner must be notified at	Funera	8830 Walther Blvd  11. Marital Status  1 Never Married 2 Married	12. Was De Armed F 1 Tyes If Yes, G	2 No Give				ispanic Orig an, Mexican	gin? (Spe i, Puerto	ecify Yes or Rican, etc.)	No-	Blad	e - Americ ck, White, v: <b>Whi</b> t	etc.	
, 15-0	hin 72 hours an "natural", Medical Exa	Completed by	Widowed 4 Divorced  15. Decedent's E (Specify only highest g  Elementary/Secondary (0-12)	rade completed		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	ation during mosi f)	t of work	ing	16b.		usiness/Ind		
2 2 2	ed witt	E O	12			Но	memak	er						Home		
; <u>r</u>	wild be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Las John Timko	st)						P	e (First, Mid Anna I	enche	ek			
	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship Patricia Cosgrove			377	4 Spr	ing	Meado	w Dr	al Route Nu	lico	tt Ci	ty, N	⁄D 21	042
10/25/01	Page Tent c		20a. Method of Disposition 1 Mag Burial 2 □ Cremation 3 i 4 □ Donation 5 □ Other (Spec		n State Pul	Place of Dispo cemetery, cre aney V	alley	ne of therplace Mem Grd	ns. 6	/25/	<sup>2007</sup>	Tir	moniu	City or To	)	
Ra#	permit. Departr Importa		21. Signature of Funeral Service Lice	Kadi	M014	42 2	2. Name an 112 O	d Addres	ss of Facilit	y Har oia F	ry H. k. El	Wit: lico	zke's tt Ci	ty, N	ily FH 1D 21	Inc. 043
218-34-05	ite be iysicii	ledical Examiner	23a. Partf. Enter the disease, or corshock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last	y one cause on  a.  Due to  Due to	caused the deal each line.  Co (or as a consect to (or a)))).	quence of):	er the mod	e of dyin	g, such as	cardiac (	or respirato	y arrest,			Approximation	ween
281 (911 PO Box	that the death certificated by the attending phyddalaeched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🗆 Live	utcome pf pregn birth 2 Det gnant at time of known	al death 3	⊒Ectopic pr ⊒ Other (sp		/			_		ate of delive		Year
- 0	w requires that been signed by should be deta	þ	Part II. Other significant conditions	contributing to		sulting in the u		-	en in Part I						ne cause of o	
v y ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	The law ate has b	Completed	Chonic Ki Diabetes	dney		as e					a	Vas an utopsy erformed? es 2 🔀 l	24b.	Were auto prior to co death? 1 ☐ Yes	psy findings mpletion of c	available ause of
Vital	Physiclan: r this certifica	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	TER/Outpatia	nt 3 🗆 DC	Oth	OF:	_	h <i>(Check oi</i> ime 5□F		c 🗆 🗆			
THUE NOVOTA	ling P	Certification: To	27. Manner of Death  1 Natural 5 Pending investigati 2 Accident investigati 3 Suicide 6 Could not determine	28a. Dat (Mo	e of Injury onth, Day Year) ce of injury - At I Iding, etc. (Spec	28b. Time of Injury	of 2	28c. Injur Worl 1 □		No	28d. Descr	be how in	jury occui	rred	y) al Route Nur	nber,
MARJE	e Hospital or Attend 24 hours after death e Funeral Director:	Medical Cer	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Ex	aminer: On the												s)
•	To the Comple	Me	29b. Signature and title of certifier	Å,	MD		290	c. Licens	e number	29	72	4	lar	200	Day, Year)	
_	EG		30. Name and address of person wh	0	Trive	n K.	Print)	m	D P	kcre arkv	ille,	MD Trage	2123		ent Co	.mun1
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 2	2007	Rigistrar's Sign	J. A.	book	,								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryian	•	tificate of l			Reg. No.	7 7	22211
		Υ	Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
ı.	Physicia /Medic		James W		Plater		June	20,	2007	9:30a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death	_		unty of Death	
4			Charlotte Hall Veterans H 5. Social Security Number 6. Sex 7. Age (In yrs.		Charlo	otte Hal	8. Date of Bir		. Mary	/S lace (State or Foreign
	Funeral Director		214-34-3075	Yrs.	Months Days	Hours Min.	04/14	y, Year)	Coun	rland
	nand ow at			ty, Town or Lo	cation	-			1	0d. Inside City Limits
	a-f sh ified	ctor	Maryland Prince Georges C	oral H	Hills					1. Yes 2 No
	th the or 28; e not	Director	10e. Street and Number		10f. Zip Code			10g. Citizer	of What Coun	try?
	ath wi		1306 Glacier Avenue		2074			US	A Race - Americ	an Indian
	er de	Funeral	11. Marital Status  1. Marital Status  1. Marital Status  1. Was Decedent Ever in UArmed Forces?  1. Marital Status  1. Marital Status  1. Marital Status	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No Rican, etc.)		Black, White,	etc.
36	ırs aft II', or Xamlı	by	1 XNever Married 2 ☐ Married 1 XNever Married 2 ☐ Married 1 XNes 2 ☐ No If Yes, Give Year or Dates: 1956	5-58	1∐Yes 2ŽMNo	Specify:		Sį	pecify: Bla	ıck
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind	of Business/Inc	Justry
21	ithin 7	mple	Elementary/Secondary (0-12) College (1-4or 5+)		_	during most of work i)	9	T 0.00	1 Corre	rnmont
	lled w tygier ther th		12 17. Father's Name ( <i>First, Middle, Last</i> )	Eng.	ineer	18. Mother's Name	e (First, Middle			ernment
and	d be f ental l ced ol	To Be	l	Spence	ar	Mary	Lo		Bor	nđ
Maryland	shoul	F	19a. Informant's Name/Relationship (Type. Print)			and Number or Rui				
	and 2 salth a salth a r 27 ls	1	Janet Wade/ Daughter	9514	Silver	Fox Tur				and 20735
ore	Jes 1 of He If iten or oth		1 K Burial 2 I Cremation 3 I Hemoval from State 1		sition (Name of matory or other plac		Date		tion - City or To	
Baltimore,	t. Pag tment tant; ijury o		4 □ Donation 5 □ Other (Specify) Ma							,Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Foneral Service Licensee			ss of Facility Ad				e PA nd 20608
			23a Part1 Enter the disease, or correlications that caused the dea						ar yra:	Approximate Interval Between
	Physician <sup>1</sup>		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		7.0	ivitis				Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a conse	quence or):			1.		-	
ř	Examiner	L	Sayus many list conditions, if any leading to immediate	Olos	stru et	ive to	Mov	av	y dis	ease
	ted	Examiner	cause Enter Underlying		sion				ا ر	
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	ntifical ng phy e as th		IF FEMALE:			COM-				-
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σ.	that the	y Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to the	he cause of death?
Vital Records,	quires n sigr uld be	q pe	Anemia of Cliv	onic	disea	rse_	1 🗆	Yes 2□	No 3□ Prob	pably 4 Unknown
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Ä	ate pag	Com	Rhoum atold Ly	ma	dise	rse		ormed? 25 No	death?	2 □ No
/ita	ysician: Th is certificate director, pag	Be	25. Was c se referred to medical examiner?	7	lou	26. Place of Deal				
0	di S	٦.	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	28b. Time o		4 S Nursing Ho	ome 5 Res			у)
on	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Wor	k? Yes 2 □ No	EGG. DOGGNIDO	now injury v	, courted	
Division	Atten r deat ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At I building, etc. (Spec	home, farm, sti	reet, factory, office		28f. Location	(Street and I	Number or Rura	al Route Number,
á	tal or s afte al Dir ed in	Certification:	a Dullang, etc. (Spec				Ony of To	wii, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.							
	To the within 2 To the complet	Me	29b. Signature and the of certifier		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
			Jane Aten		Di	15092		6		700
9	8291		30. Name and address of person who completed gause of death (Ite	em 23a) (Type,	Print) 205	5 Pri	nce	Free	drick	i,MD
	Sta Registi		31. Date filed (Month, Day) Year)  32. Pegistrar's Sign  JUN 2 6 2007	nature	bank			-		20678
	negisti	·ui	JUN 2 6 2007 Decem	~ /4/						•

Records, P.O. Box 68760,

Division or Vital

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Examiner Physician/Medical <u>م</u> Be Completed Certification: To Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or items 23a or 28a-f shov dical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ntt: If item 27 is marked other than "natural", or iten iry or other traumatic event, the Medical Examiner

Department o Important: If any injury or once.

Baltimore, Maryland 21215-0036

death with

Director

Completed by Funeral

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sepsis, stroke, acute renal failure 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58681 June 22,2007

State Registrar

DHMH 17 Rev 1/2001

9901 Medical Center Way Rockville, Md. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

egistrar's Signature

Alexander

Jude

31. Date filed (Month, Day, Year)

JUN 2 6

JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#8perFH6/26/07, BMW, MbCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Victor S. Robertson **Physician** 6:20amm 22, 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | 0.8 / 2.1 / 5. Social Security Number Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 953 Months Days 1**⊠** M 2□ F 53 Washington, DC Director 587-66-5670 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at angle. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Calvert Lusby 1 Yes 2 No Director Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12122 Monterey CT 20657 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Alarm Tech 12±h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor S. Robertson Sr Mary Williams ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Robertson wife 1311 Decatur St NW Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 6/30/07 Washington, DC Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snead Mortuary Service, P.A. 21. Signature of Funeral Service Licensee 1409 Fairlakes Pl Ste B Bowie, Md 20721 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jiscase or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SUPRAGIOTTIC SQUAMOUS CELL CA LARYNX COPD, HTN 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho MRSA INFECTION, VRE BRONCHITIS CACHEXIA PE 24a. Was an page 2 s autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: / d in by the f 2 ☐ Accident 6 Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Division or Vital Records, P.O. Box 68760

within 24 hours a

To the Funeral C

completely filled

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

JUN 2 6 2007



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D36969

29d. Date signed (Month, Day, Year)

22/07

LUSBY MD 2065

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Steven Rocco Saccone, Sr. 0442M 2007 Juli 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year) Days 1**X** M 2□ F 54 18, 1952 105-44-0498 Sept. New York Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1**X** Yes 2 □ No Chewsville Washington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21721 U.S.A.21131 Twin Springs Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 22 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Security Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael L. Saccone Mabel I. Small 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21131 Twin Springs Dr. Chewsville, Maryland 21721 (Wife) Antonia M. Saccone 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 6, 1 Burial 2 □ Cremation 3 □ Removal from State Smithsburg Cemetery Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home M01414 12525 Bradbury Ave. Smithsburg, Maryland 21783 AVIS Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the u pring cause given in Part 3 Probably 1 ☐ Yes 2 □ No 4 ☐Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

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Completed

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**Funeral** 

Director

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Department of Health Important: If item 27

1 and 2 should be

Pages '

with the Maryland

Maryland 21215-0036

Baltimore,

Box 68760

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Records,

Division or Vital Hospital or Attending Physician;

After

24 hours after death Funeral Director;

within 2

Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown

Hospital: 2 DOA 3 DOA 1 Inpatient

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide determined

25. Was case referred to medical examiner?

28a. Date of Injury (Month, Day Year)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

Completed by

Be

Certification: To

Medical

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ture and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who

32, Registrar's Signature

DHMH 17 Rev 1/2001

State

			For State Registrar	State	of Maryl		artment of F		and Me	ental I	Hygi∈ Reg	- C- U	] 7	22314
	Dhusiai	1	1. Decedent's Name (First, Middle			1_				2. Date of		Day	Year	3. Time of Death
	Physici /Medic	_		Leonard	Sams,	Sr.				June	24,	2007		10:24 P <sup>M</sup>
\$	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o					4c. County		
			Charlotte Hall 5. Social Security Number	Veterans 6. Sex		yrs. last birthday)	Charlo1	If Under a		B. Date of	f Righ	St	. Ma	ry'S place (State or Foreign
-87	Funeral Director		233-18-9295	1 X M 2 ☐ F	89		Months Days	Hours	Min.	(Month	Day, Y	.918	Coni	t Virginia
			Usual Residence of Decedent		0.5					unc	J, 1	. 710	HC3	o riigiiiia
	yland		10a. State 10b. County		10c	. City, Town or Lo	cation							10d. Inside City Limits
	e Maria-fs	ctor	Maryland Char	les		Waldorf								1 Tyes 2X No
	ith th	Director	10e. Street and Number				10f. Zip Code				10g	. Citizen of V		,
	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23s or 28a-1 show ant, the Mydred Exertains or must be invitited at	ra	2797 Desert Sun				2060			4.34	. N.	14 000		SA
	ltems	Funeral	11. Marital Status  1 □ Never Married 2 Married	Armed	ecedent Everi Forces? s 2 ☐ No	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	tispanic Orig an, Mexican	gin? (Spec i, Puerto R	ican, etc.	r No- )		ck, White,	can Indian, etc.
39	irs aff	by F	3 Widowed 4 Divorced	If Yes, C	Give		1□Yes 🗶 No	Specify:				Specify	<i>r</i> :	White
5-0036	2 hou	Completed	15. Deceden		-0	16a. Dece	dent's Usual Occup	ation			16	b. Kind of Bu	usiness/In	
2	e. e. "n	ple	(Specify only higher Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	kind of work done DO NOT use retired	d) auring most	or working	g				
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a N	C1 00 -20 00		19a. Informant's Name/Relations		•		ng Address (Street				_			
<u>ب</u>	1 and Health em 27		Frank L. Sams,	JI' 30!		b. Place of Dispo	ost Office sition (Name of		, Su i			c. Location -		
ltimore,	ages int of t: If it		1 🕅 Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		m State		matory or other place Memorial		627	_ก7	Wa	ldorf,	MSD	
Ħ	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service		MOOC		2. Name and Addre				_			on Road
Ba	Depar Impo any ir		Nack M	Broke	فسي		untt Fune	eral H	ome			MD 2		on Roud
	7		23a. Part1. Enter the disease, or shock, or heart failure. List	complications tha	t caused the									Approximate Interval Between
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	/Medical		resulting in death)  a  Due to (or as a consequence of):											
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	physics the l	dicai		dN	Juli	ecos.								
× 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of pre	egnancy						23d. Da	te of deliv	erv
Вох	Jeath a atter	iciar	in the past 12 months?	4☐ Pre	e birth 2 □ I gnant at time		∃Ectopic pregnancy ∃ Other (specify)	<i>y</i>			_		nth	Day Year
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Division of Vital Records, P.O.	s tha	by P	Part II. Other significant condition	ons contributing to	death but not	t resulting in the u	nderlying cause giv	en in Part I.		23e. (	Did toba	cco use cont	ribute to t	the cause of death?
ğ	w requires to been signer should be considered.	pe									1 ☐ Yes	2 □ No	3 🏻 Proi	bably 4 □Unknown
000	ne law re has bei ge 2 sho	Completed									Mas an	24b.	Were auto	opsy findings available ompletion of cause of
Œ.	The ate has page	mo.								10 4	performe	d?	death?	
Ita	i <b>cien:</b> Th certificate rector, pag	Be (	25. Was case referred to medica examiner?						of Death	(Check o	nly one)			
× ×	Physical this call direct	은	1 ☐ Yes 25 No			2 ER/Outpatier		4 Nu	_			e 6 □Oth		fy)
ū	ding P h. After I funera	on:	27. Manner of Death  1 ★Natural 5 ☐ Pendir	g (Me	te of Injury onth, Day Yea	ar) 28b. Time o	Wor			8d. Descr	ribe how	injury occur	red	
Sic	Attending Physicien: or death. ector: After this certifically the funeral director, I	icat	2 Accident investig	not be as Die	on of Injury	At home form et		Yes 2□I		28f. Location (Street and Number or Rural Route Number,				al Route Number
<u>&gt;</u>	l or Attendatter deatt after deatt Director:	Certification;	4 Homicide determ	ined 200. Pla	Iding, etc. (Sp	pecify)	eet, factory, office		20	City of	r Town,	State)	or or man	ar riodio ridinoci,
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifyir	g Physician: To i	the best of my	knowledge, deat	h occurred at the tir	me, date an	d place, ar	nd due to	the cau	se(s) and ma	anner as s	stated.
	10 Ho	edical	(Check only 2 Medical one)	Examiner: On the	basis of exam anner stated.	mination and/or in	vestigation, in my o	pinion, dea	th occurred	d at the ti	me, date	and place,	and due t	o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie		_		29c. Licens	se number			290	. Date signe	d (Month,	Day, Year)
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(	. 0 = 1		30. Name and address of person											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:55 P M **Physician** Beverly B. Smith 20 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel Glen Burnie Health & Rehab. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** 1 M 2XX 83 218-16-3361 1923 Maryland June 26, Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Annapolis 1 ☐ Yes 2€XNo Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 U.S.A. 2674 Crest Cove Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 223No If Yes, Give 11. Marital Status 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify <u></u> 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Harry Bell Ida Hyde 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon B. Evans/daughter 2674 Crest Cove Annapolis, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 6/25/2007 Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknowr signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 💢 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: 24 hours after death. filled in by the within 2. To the I

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

OCHANE

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) strar's Signature 5 2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-40521

75 HOSPITAL DRIVE SWITE 208 EN BURNIE, MD 21061

29d. Date signed (Month, Day, Year)

June 21, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2007 **Physician** АМ 24, 7:30 June Gracemary G. Snyder /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Mitchellville Collington Life Care Community If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y Sept 18, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex Year) 1920 Pennsylvania **Funeral** 1 ☐ M 2 🖾 F 86 **Director** 176-16-4751 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County la or 28a-f show t be notified at Show 1 ☐ Yes 2 ☐XNo Prince George's Mitchellville MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number is 1 and 2 should be filed within 72 hours after death wind Health and Mental Hygiene.

item 27 is marked other than "natural", or Items 23a other traumatic event, the Medical Examiner must to 20721 USA 10450 Lottsford Road #335 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 A Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Specify: ≥ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seminary 5+ Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Hook Levan Homer Cornell Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10450 Lottsford Rd. #335 Mitchellville,MD 20721 Pages 1 and 2 C. Kenneth Snyder/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Chesapeake Crematory: 06/26/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service 21. Signature of Funeral Service License P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart falkere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician <sub>a</sub>Fatal Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a cunsectuance of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami <sub>c.</sub>Hypertension and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a l∐Yes 2.DXNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. <u>6</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the linector, page 2 s autonsy performe 2 1 No 2□ No 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No မ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: (Month, Day Year) Injury 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident d in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide in 24 hou.c. the Funeral Dir∉ 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2.

State Registrar

31. Date filed (Month, Day, Year) JUN 2 7 2007

29b. Signature and title of certifier

Cielito Aguinaldo, M.D. 1221 Mercantile Lane Largo, MD 20774 32. Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D41945

29d. Date signed (Month, Day, Year)

06/25/07

			State of Maryland / Departm  State of Maryland / Departm  State of Maryland / Departm  Certific	nent of Health and M cate of Death		ene2007	22317						
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death						
	Physicia		Jules H. Sigal		June 21,	2007	12:10 PM						
	/Medic Examin			City, Town, or Locetion of Death		4c. County of Deat	h						
	LAGITHII	Ç1	Brooke Grove Rehab and Nursing S	andy Spring		Montgome	⊃ <b>r</b> v						
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If U	Inder 1 Year I If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign						
	Funeral Director		048-22-7871 15 2 F 95 Yrs. Mor	nths Days Hours Min.	Aug. 10,	1911   Com	necticut						
			Usuat Residence of Decedent										
	/land		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
	Man	ğ	Maryland Montgomery Silver Spr	ing			1 ☐ Yes 2X No						
	28a	ec	10e. Street and Number 10	f. Zip Code	10	g. Citizen of What Co	untry?						
	with with	٥	3330 N. Leisure World Blvd.	20906		United Sta	ates						
	hours after death with the Maryland tural, or iteme 23a or 28a-f ehow al Examinan must be notified at	Funeral Directo	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was F	Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	rican Indian,						
	iter d	늘	Armed Forces? If Yes,  1 □ Never Married 2 Married 1 Married 2 No	specify Cuban, Mexican, Puerto	Rićan, etc.)	Black, Whit	•						
5	rsaf t', or	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII 1 ☐ Ye	es 2 🖾 No Specify:	_	Specify: Wh:	ıte						
21215-0030	hou tura			Usual Occupation	1:	6b. Kind of Business/	Industry						
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7	tha.	Completed	Elementary/Secondary (0.12) College (1.4or 5±) Lawyer			Law							
N 0	i be filed within ntal Hygiene. ed other than " event, It a Me	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	aiden Sumame)							
/land	ntal od o	<b>m</b>	Clarence Sigal	Fanny (1	unk)								
=	J Me J Me nark natio	၉		dress (Street and Number or Rui	al Poute Number	City or Town State	Zio Codel						
Mar	n an h an 7 is r		Shirley Sigal -wife 3330 N.	Leisure World Blvd	. SilverSp	ring, Mar	vland 20906						
<b>a</b>	Healt Healt her		20h Place of Disposition	/Name of	Date 2	Oc. Location - City or	Town State						
altimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan tent of Heatth and Mental Hygiene. I need of Heatth and Mental Hygiene. In: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show iny or other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, crematory  1 □ Approximation 3 □ Removal from State	rial Gardens 6/2	24/2007 0	Inov Mary	vl and						
E	Pa men men men men men men men men men men		t 22 of fallow of 2 of the Copenity				y Latio						
<u></u>	permit. Pages Department of t important: if its any injury or o		21. Signature of Funeral Service Licensee	ne and Address of Facility Boryward	t Funeral	Home, PA							
п	g Q 75 5 9		Keun K. Homas 4400	Powder Mill Ro	oad Belts	ville, Ma	rvland 20705						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
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	/Medical		disease or condition resulting in death)  a. Congestive Heart Fa	11016			O IIIOITUIS						
	Examiner		Atherosclerotic Car		1 year								
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×	death certifi e ettending p ed for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	liven						
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g	ician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Dea	th (Check only one								
		0 8	examiner?  1 Yes 2 XNo  Hospitat: 1 Inpatient 2 ER/Outpatient 3	Other			ocify)						
ō	Phys or this oral di	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe hov								
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2	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, for	actory, office		eet and Number or R	ural Route Number,						
Division	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)							
_	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occur	urred at the time, date and place	and due to the ca	use(s) and manner a	s stated.						
	24 h Fur etely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigence)	jation, in my opinion, death occu-	rred at the time, da	te and place, and du	e to the cause(s)						
	ithin o the	₩		29c. License number	29	d. Date signed (Mon.	th, Day, Year)						
			296. Signature and title of centrer	D050545		June 23,	2007						
1	V												
			30. Name od admiss of person who completed cause of death (Item 23a) (Type, Print; Godswill O. Okoji, M.D. 7513 New Hampshi		Park Mo	ryland 20	912						
					TOTK, INC	Lylond 20	712						
16	Sta Registi		31. Date fited (Month, Day, Year)  JUN 2 6 2007  32. Igistrar's Signature	a)									

			For State	St	ate of N	/larylan	d / Depa <i>Cer</i>	rtmen tificate			nd Mei		jiene leg. No.	2007	22318
		atv .	Registrar     Decedent's Name (First, Michael Control of the		2. Date of				Date of Death 3. Time o			3. Time of Death			
	Physician Lorraine Schrier										J	une 23	, <sub>20</sub>	07 Year	1:00P M
	Examin		4a. Facility Name (If not institut 4058 Norbeck S	Facility Name (If not institution, give street and number) 058 Norbeck Square Drive						4b. City, Town, or Location of Death Rockville			4c. County of Death  Montgomery		
	Funeral		5. Social Security Number 214-38-5229   6. Sex 1 □ M 2√2 F   67   7. Age (In yrs. last birthday for 1 □ M 2√2 F   67   7. Age (In yrs. la						1 Year Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Day 8/1/19	3 <sup>Year)</sup>	place (State or Foreign Intry) Maryland	
4	Director		Usual Residence of Decedent												
	show	_	10a. State 10b. Cour				y, Town or Lo								10d. Inside City Limits 1 X Yes 2 □ No
	he Ma 28a-f	Director	MD Montgomery Rockvil						Code				10g. Citizen of What Country?		
	with t	I Dir	4058 Norbeck Square Drive					,	0853				United States		
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If them 27 is marked other than "natural" or items 23a or 28a-f show it if item 27 is marked other than "natural" or items 20a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ★ M 3 □ Widowed 4 □ Divorce	arried 1	Vas Decede Armed Force ☐ Yes 2[ If Yes, Give Year or Date	XNo		Was Deced If Yes, sped	cify Cubar	spanic Origin n, Mexican, F	n? (Specif Puerto Ric	y Yes or No- can, etc.)		4. Race - Amer Black, White Specify:	
5	'2 hour natural ical Ex	ted t		ent's Educatio	nnleted)		16a. Dece	dent's Usua kind of wo	al Occupa rk done d	ation furing most o	of working		16b. Kin	d of Business/I	ndustry
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7	iiled w Hygiei ther th		17. Father's Name (First, Midd				Dice					First, Middle,			
ğ	id be ental ked o Ic eve	To Be	Jack Rubin	•					1	Sadi	e Be	rman			
<u>2</u>	shou and M s mar	-	19a. Informant's Name/Relation	nship (Type. I	Print)			•	,					Town, State, Z	
, Z	and 2 ealth m 27 I		Steven Schrier	- Son		20h F	409 Place of Dispo			on Dri	ve G			g MD 20 ation - City or	
Dallillore	permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trae		20a. Method of Disposition  1  Burial 2  Crematic  4  Donation 5  Other		oval from Sta		dean M	matory or d emori	al G	rdns	6/26	/07	01ne	y, MD	
Dall	permit. Departr Importa any inj		21. Signature of Funeral Serv	ce Licensee	<b>\_</b>	•								uneral MD 2085	Direction 2
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k.	/Medical Examiner		resulting in death)	<b>1</b>	Due to (or	as a conseq									
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'n	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	Due to (or	as a consec	juence of):			-	-				
g/en	cate be ohysicia the bu	dical		d											
O. BOX 6	death certifi e attending d for use as	hysician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown		1☐Live birt	me pf pregn h 2 □ Feta nt at time of c n	al death 3	⊒Ectopic p ⊒ Other (s		/			2	3d. Date of del Month	ivery Day Year
ρ. J.	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use co								o the cause of death?				
Vital Record	sician: The law requires that the certificate has been signed by the irector, page 2 should be detache	Completed							aut				opsy prior to completion of cause of death?		completion of cause of
<u>ta</u>		0	25. Was case referred to med	ical						26. Place	of Death	1□ Yes Check onl	2 kg No one	1∐Yes	2 110
<u>-</u>	nysici nis cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hosp	oital: 1 □ Inp	atient 2	ER/Outpatie			4 □ Nurs				3 □Other (Spe	cify)
o uo	th. : After the function		27. Manner of Death  1 Natural 5 Pe 2 Accident		28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	of M	28c. Injur Wor 1 □	yat k? Yes 2∐N		3d. Describe	escribe how injury occurred		
Division or	i or Atter after dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, building, etc. (Specify)					street, factory, office 28f. Locatio				tion (Street and Number or Rural Route Number, or Town, State)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier 1 Cert (Check only one) 2 Med	fying Physici cal Examîner	an: To the bas On the bas	is of examin	owledge, dea ation and/or i	th occurre	d at the ti	me, date and opinion, deat	d place, a th occurre	nd due to the	cause(s) , date and	and manner a d place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of cer	tifier	1	- /	,			e number				te signed (Mon	
	10		fund	MI	Sur	M	mo		D359				Jur	ne 24, 2	
	1 -		30. Name and address of per Linda Burrel	son who comp MD 27						eaton	MD 2	20902			
	St Regist	ate trar	31. Date filed (Month, Day, Y	6 2007	32 Ne	gistrar's Sigr	B A	and i	,						

			1 - State Amend #7	State of M. 6-26-07,	aryland <b>per</b>	/ Depa	rtment of F HCHD wilcate of	lealth and Death	d Menta	l Hygien	e 200	7 999	: 0	
1		4	Decedent's Name (First, Midd						2. Dat	e of Death		3. Time of Dea	ath	
*	Physici /Medio		Amelia H. Tur	ner					June		ay Yes 2007	1:45	P <sup>M</sup>	
	Examir		4a. Facility Name (If not institution	-			4b. City, Town, o	r Location of De	eath	4	c. County of D			
			9217 Winding 5. Social Security Number		an /In um Inc	at hirthdays)	Ellico	tt City		e of Birth	Howard			
Е	Funeral Director		218 48 8958	1 N OFF	ge (In yrs. las		Months Days		lin. (Mo	nth, Day, Yea	r)	Birthplace (State or Fo Country)	oreign	
ad.			Usual Residence of Decedent						UCT.	27, 1	.948 Ma	aryland		
	nylan show	_	10a. State 10b. County	/	10c. City,	Town or Loc	cation					10d. Inside City L		
	Ba-f s	Director	MD How	ard	E11	icott						1 □ Yes 2	X <sub>NO</sub>	
	with the		10e. Street and Number				10f. Zip Code				Citizen of What	Country?		
	death with the Marylan ns 23a or 28a-f show must be notified at	Funeral	9217 Winding W	- The -	Ever in U.S.	13. V	21043	ispanic Origin?	(Specify Ye		ISA 14. Race - A	merican Indian,		
(0	r iten	표	1 ☐ Never Married 2 Mar	12. Was Decedent Armed Forces? rried 1 ☐ Yes 2 🔀	No	Ì	Vas Decedent of F Yes, specify Cub		uèrto Rican, e	etc.)		/hite, etc.		
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	l by	3 Widowed 4 Divorced	d If Yes, Give Year or Dates:		1	□Yes 2½ No	Specify:			Specify: V	√hite		
5-0	72 hc 'natur dical	Completed	15. Decede (Specify only highe	nt's Education est grade completed)	- 4	16a. Deced	ent's Usual Occup kind of work done OO NOT use retired	ation during most of	working	16b.	Kind of Busine	ss/Industry		
121	within iene. than "	dm	Elementary/Secondary (0-12)	College (1-4or s	5+)			•	-					
	e filed vall Hygic other vent, th		17. Father's Name (First, Middle	, Last)		Sare	s Associ		Name (First,	Middle, Maide	etail en Surname)			
Maryland	ld be ental ked o	To Be	Gordon Holsin	ger						B. Cli				
ary	2 should be and Menta is marked aumatic ev	-	19a. Informant's Name/Relation			19b. Mailin	g Address (Street	and Number or				e, Zip Code)		
	is 1 and 2 of Health a Item 27 is other trau		Paul D. Turne	r /husband		9217	Winding V	Vay El	licott	: City,	MD 21	1043		
altimore,	ges 1 and 2 should be filed within 72 hours after dea it of Health and Mental Hygene. If Item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner miner.		20a. Method of Disposition  ★□ Burial 2 □ Cremation	3 □Removal from State	20b. Plac	ce of Dispos netery, cren	sition (Name of natory or other plac	ce)	Date	20c.	Location - City	or Town, State		
ij	t. Pag tment tant:		4 Donation 5 Other (	Specify)	Cres		Mem. Gar					sville, MD		
Bal	permit. Pages Department of Important: If It eny injury or o		21. Signature of Funeral Service	L'Kada	M01442 /	010	d Columb	ia Pk.	Ellic	xott Ci	zke's F ty, MD	Family FH 3 21043	Inc.	
г	Physician		23a. Patr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
4			Immediate Cause (Final disease or condition resulting in death)  a. Metustute Sophingla (ancev 6 month)										45	
1	/Medical Examiner		Due to (or as a consequence of):											
В		-	Sequentially list conditions, b.  Due to (or as a consequence of).											
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,								
oʻ	exec an and rial-tra	Еха	resulting in death) Last  Due to (or as a consequence of):											
68760,	ficate be executed physician and s the burial-transit	edical		d										
_		Med	IF FEMALE:	23c. If yes, outcome										
Box	leath certifi attending I for use as	ian/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy	,			23d. Date of delivery  Month Day Year						
P.O.	The law requires that the death certi te has been signed by the attending tage 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐ Other (specify)											
	that the by detact										23e. Did tobacco use contribute to the cause of death?			
rds	quires n sigr uld be	d by	-						_ [,	1 🗌 Yes	2□ No 3□	] Probably 4 🕱 Unkr	nown	
00	aw requir s been s	Completed							24:	a. Was an	24b. Were	autopsy findings avai	ilable	
Ä	The lav	mo							_	autopsy performed? Yes 2 3	death	to completion of cause h? /es 2□ No	e of	
ita	iclan: Th certificate ector, pag	Be C	25. Was case referred to medica examiner?	al				26. Place of I			10 101	63 2 110		
۲ ۷	Physic this or al dire	10 T	1 ☐ Yes 2 ☐ No	Hospital:			3 DOA Oth	4 L Nursin	g Home 5	Residence	6 □Other (S	Specify)		
n c	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death  1  Natural  5 □ Pendi			8b. Time of Injury	28c. Injur Wor		28d. De	scribe how inj	jury occurred			
isio	ttend death stor: /	icati	3 Suicide 6 Could		un/ - At hom	o form etro	M 1	Yes 2 □ No	201 Los	ention (Ctroot	and Number	Devel Davida Novela		
Division or Vital Records,	after after I Direct	Certification:	4 ☐ Homicide deterr	building, et	tc. (Specify)	e, iaiii, siie	et, ractory, office			or Town, Sta		r Rural Route Number,		
	To the Hospital or Attending Physician: The within 24 burns after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page		(Check only 2 ☐ Medica	ing Physician: To the best I Examiner: On the basis o	of examinatio									
	To the within 2 To the Complet	Medical	29b. Signature and the of certific	and manner sta	ated.	<del></del>	29c. Licens	e number		29d. D	Date signed (Ma	onth, Day, Year)		
	P 5 P Ö		> fees 2	Kumly			2	1858	87				7_	
(b)	3		30. Name and address of person	who completed cause of d	leeth (Item 2	3a) (Type, F	Printy A	re	Bai	Himo	ve m	10 2122	9	
*	Sta Registr		31. Date filed (Month, Day, Year JUN 2		rar's Signatur	* A	berte		<i>V</i> = - <i>V</i>	,				

			1 - For State Registrar	State of Ma		partment of H			giene 007	22320			
	Physic /Medi	cal	Decedent's Name (First, Middle, Dorothy	Hudson		Taylor			25 2007	3. Time of Death 8:15 A M			
	Examir Funeral Director	ner	4a. Facility Name (If not institution, Gull Creek Reti 5. Social Security Number 216-09-9715	rement Commur	nity (In yrs. last birthda 94 Yrs.	Berlin	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da					
20	Maryland f show	tor	Usual Residence of Decedent		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2★ No			
	h with the 23a or 28a- st be notifi	al Director	10e. Street and Number Gull Creek Ret 1 Meadow St. #	irement Commu	Berli Inity	10f. Zip Code 2181	1		10g. Citizen of What Country?				
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 X Widowed 4 Divorced	12. Was Decedent Ev Armed Forces?	rer in U.S. 13	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)					
21215-0036	a within 72 ho piene. r than "natur the Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12		(Giv	edent's Usual Occupa ye kind of work done of DO NOT use retired r/ Operato	during most of wor	king	16b. Kind of Business Hotel/Mo				
Maryland 2121	d ta b	To Be C	17. Father's Name (First, Middle, L John Hillary H	ıdson			18. Mother's Nam	ale Deni	Maiden Sumame) nis				
	1 and 2 s Health ar In 27 is		19a. Informant's Name/Relationsh  Lynne Taylor Mu:  20a. Method of Disposition  1 ☆Burial 2 □ Cremation	cray - Daught	er 1234 20b. Place of Dis	9 Vivian S	Street, E	Bishopvi Date	nr, City or Town, State, 1 11e MD 218 20c. Location - City or	13			
Baltimore,	permit. Pages Department of I Important: If Ite any injury or or once.		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L	ecify)		am Pres. ( 22. Name and Addres	ss of Facility The	28/07 Burbage	Berlin Funeral H	ome			
Phys /Me Exan	Ate be executed hysician end hysician end Examiner transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last  Due to (or as a consequence of):										
O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the press 12 pronths? 1 Yes No. 9 Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown		23d. Date of del Month	ivery Day Year						
ecords, P	w requires that the death been signed by the atte should be detached for	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did							o the cause of death?			
r	The lay ate has page 2	e Completed	25. Was case referred to medical	1 Yes	prior to completion of cause of death?  2 No 1 Yes 2 No								
Vision of Vital	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification: To B	examinar?  1 Yes No  27. Manner o Death  Natural 5 Pending investiga  2 Accident 6 Could or	t bo	/ear) 28b. Time Injury	26. Place of Death   Check only one   FR/Outpatient 3 DOA   Other: 4 Nursing Home   Residence 6 Dother (Specify)    28b. Time of Injury at Work?   M 1 Yes 2 No							
2	spital or At ours after of nerel Direct filled in by	al Certiff	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State) 28g. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner										
	To the Howithin 24 h	Medical	(Check only one) Medical E	ceminer: On the basis of each manner state	xamınation and/or i	29c. License	oinion, death occur	rred at the time, o	date and place, and due	h, Day, Year)			
t	3A6		30. Name and address of person w	M Coosto	1 Henry	PO POX 1	733 S	alish,	6-26 MO 218	02			
	Sta Registr		JUN 2 7	32. pegistrar's	s Signature	parte		0					

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last). 2. Date of Death **Physician** UNE 23 900 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MARYLAND HEALTH CARE SYSTEM DEKRY POINT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y) NAME KNOWN TO PINSTOCIAN : TURNER, GEORGE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Months 38-836 M 2 F 66 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 1 Yes 2 No Wicomico Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or a 1804 SA Pages 1 and 2 should be filed within 72 hours after death one of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 66 − 67 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 'natural", or Specify: BLACK 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tarming FARM Laborer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 TUSCOLA ave Salisbuen *ldaughter* permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 107 Beulah, Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith 21. Signature of Juneral Service Licens SALISBURY, md 21801 Funeral Home Approximate Interval Between Onset and Death 23a. P 144 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Tes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year, Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) JUN 2 6

VA MARYLAND HEALTH CARE SYSTEM, PERRYPONT, MOUND

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elizabeth Vickers Constance 06 2336 22 67 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner NICOMICO VENINSULA REGIONAL MEDICAL LENTER ALISBURY Under 1 Year | If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 F 81 220-26-1096 Director Maryland 11/30/1925 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10h. County 28a-f show a or 28a-f sho t be notified a 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA items 23a 1514 Riverside Drive 21801 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2**X** No Specify: white Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental F Important: If Item 27 Is marked of any Injury or other traumatic ever once. Theresa Brumbley Joseph Guy Naples ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 Sandy Beach Dr., Dagsboro, DE 19939 Karen Lynn Clark/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial 6/28/07 Salisbury, MD Park 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 of Funeral Service Licensee CESP bongonda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespiratory **Physician** /Medical Due to (or as a consequence of): Examiner Ulmonay Disease hnaric Obstructu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine History Unknown tobacco The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 5 ☐ Other (specify) ed by the a detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by leura 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an orgestic perform death? 1 ☐ Yes 2□ No To the Hospital or Attending Physiclan: Be 25. Was case referred to medical examiner?
1 ☐ Yes 2 → Yo 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28h Time of 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No d in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

within 24 hours a To the Funeral I

no withe law to

31. Date filed (Month, Day, Year) JUN 2 6 2007

Wilson Mino, MP

12137 ElmStreet 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29c. License number

Princess Anna MD 21853

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician EDWARD** WILLIAMS 11:30P<sup>™</sup> 24, 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPICE - DOVE HOUSE CARROLL WESTMINSTER 8. Date of Birth (Month Day, Year)
May 10, 1921 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 14 M 2□F Days Hours 86 Maryland 214-16-4154 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland | Carroll Mount Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1108 North Main Street 21771 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Western Maryland Elementary/Secondary (0-12) College (1-4or 5+) Time Keeper Railway Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Charles A. Williams Nellie Seigman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Self by prearrangement 1108 North Main Street, Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) Zion Lutheran Cemetery 6/28/07 Middletown, Maryland 21. Signature of Funeral Service Licenses Molesworth-Williams P.A., Funeral Home forest 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonan Obstructive Chrenic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any sea find L immunications cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Disease Completed peen 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 7 No certificate 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \times \square$ Other (Specify) HOSPICE 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 1/Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

death certificate be executed P.O. Box 68760 Division or Vital Records,

3altimore, Maryland 21215-0036

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death.

State Registrar

Medical

29b. Signature and title of certifier

29c. License number

1 IX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lushington Heights Med. Ctr; Westminst

Imanoe 218 DO

4 Homicide

(Check only one)

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Meredith E. Wheatley  $\rho$ M 1320 2007 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Costal Hospice at the lake Wicomico Salisbur If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 8-28-1954 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2□F 214686232 52 Delaware Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2XINo Director Maryland | Wicomico Salisburv Items 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 4804 Nutters Cross Road USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. after 1 Never Married 2 Married or, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify þ hours ; 3 Widowed 4 Divorced "natural", filed wit. \* Hygiene. \* \* Than "natu.. \* Medical Ex Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restorer Piano 12 s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Shorter Charles Nichols Wheatley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ellsworth M. Wheatley/Brother 467 Dueling Way, Berlin, Maryland 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages . 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Crematory of Delmarva 6/20/2007 Delmar, Delaware 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean CIty ROad, Salisbury, MD 21802 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 autopsy performed? res 2 No certificate 1 Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3□ DOA 2 this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No **Z** ☐ Accident Director: d in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the

State Registrar 29b. Signature and title of certife

31. Date filed (Month, Day,

.Calall

Name and address of person who completed cause of death (Item 23a) (Type, Print)

035tm

32. Regist

29c. License number

29d. Date signed (Month, Day, Year)

### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Gilbert Conrad Wagner 2007 June 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year 1 M 2 ☐ F Yrs Mar. 12,1936 71 Director 219-32-8965 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County or 28a-f show Cambridge MD Dorchester Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 USA 1020 Wagner Point Road or items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. Baltimore, Maryland 21215-0036 $_{/\!\!/}$ 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify. þ 3 Widowed 4 Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 inventory manager telephone company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Walther Phillip Wagner ဥ 19a. Informant's Name/Relationship (Type. Print) wife Jean Wagner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/26/07 Zion Church Cemetery Funeral Service Licensee 21. Signature 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (of as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 🗌 Yes Completed 24a. Was an performed? Yes 20 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Tes 2 Accident 3 Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 XNo

Maryland

white

10:15 p<sup>M</sup>

Year

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 Wagner Point Rd., Cambridge, MD 20c. Location - City or Town, State Baltimore, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete use of death (Item 23a) (Type, Print) in en **ORIGINAL** 

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

State Registrar

Medical

4 Homicide

(Check only one)

31. Date filed (Month, Day,

29a. Certifier

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 06 Whittaker 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury If Under 1 Year | If Under 24 Hrs. Wicomico Coastal Hospice at the Lake 8. Date of Birth (Month, Day, Year) 9-27- 1929 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1□ M 22 F 213241492 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 28a-f show notified at **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be I Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Internation 27 is marked other than "natural", or items 23s 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Production Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 20b. Place of Disposition (Name of cemetery, crematory or other place) M.t. Peer Cemeter 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 Rurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State Marion Station 6-20-07 21. Signature of Funeral Service Licensee FUNERAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner HYPRRCALIEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed

within 24 hours after death Fo the Funeral Director:

Be

Certification: To

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2 Accident	Pending investigation	(	Date of Injury Month, Day Year)	28b. Time of Injury	М		Injury at Work? 1 ☐ Yes	2 □No	28d. E	escribe ho	w injury	y occurred
	Could not be determined	28e. F	Place of injury - At home, farm, street, factory, office building, etc. (Specify)						ocation (St lity or Town		d Number or Rural Route Number, )	
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(Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005 8410 30 BOX #1733 SALISBURY WOZI802

Month

29d. Date signed (Month, Day, Year)

Day

3 Probably

Year

Year

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

COASTAL HOSPICE 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle, Last 2. Date of Death 3. Time of Death Year Month Day **Physician** Muriel Ruth Yetter 2007 7:27 A June 23 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner <u>Rockville</u> Shady Grove Adventist Hospital Montgomery 7. Age (In yrs. last birthday, if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Months 1 M 2 X Director 154-14-7392 85 April 26,1922 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'natural", or Items 23a or 28a-f show dicai Exa<u>miner must be notified at</u> 1 ☐ Yes 2 No Montgomery Village MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19310 Club House Road 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medicai 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Own Home Homemaker of Health and Mental Hygie Item 27 is marked other other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Ernest Leins Marion Eckhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Arthur Yetter/Son 9136 Bobwhite Circle, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory June 24 2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock bear failure. List only one cause on each line. Approximate Interval Between Onset and Death immed ate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY /Medical Due to (or as a consequence of) **Examiner** TENSION NEUMOTHORACES Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed EMPHYSEMA burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE nse ( 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? sate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2XNo Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 KER/Outpatient 3 □ DOA ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide ö Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

completely

To the I within 24

> 31. Date filed (Month, Day, Year) 26 JUN 2007

R.

(Check only one)

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 64841

29d. Date signed (Month, Day, Year)

2007

20850

JUNE 23

ROCKVILLE

		Please 1	ype or Print in E	lack In	delible Ink	. Ensure A	II Copies	Are L	egible.			
		For	State of Marylan	d / Depa	artment of H	lealth and I	Mental Hy	giene				
		1 - State Registrar		Cei	rtificate of	Death		Reg. No.	007	22328		
Physici	ian	1. Decedent's Name (First, Middle, Last,					2. Date of De		Year	3. Time of Death		
/Medi	cal	Clara Bartz	Arneson				July 10			1:52 А м		
Examir	ner	4a. Facility Name (If not institution, give	,			or Location of Death	1		ounty of Deat			
Funeral	4	Southern Maryland  5. Social Security Number 6. Sec		ast birthday)	Clinton If Under 1 Year	If Under 24 Hrs.	8. Date of Bir			George's		
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or iter	匝	1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	'		Hispanic Origin? (Span, Mexican, Puert	o Rican, etc.)		Black, White	e, etc.		
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iled w		17. Father's Name (First, Middle, Last)		Sec.	retary	10 Mathada Nas	o /Firek Adiabate					
d be f antal h ed of	Be	William F. Bart	Z			18. Mother's Nam Katie	A. Sage		irname)			
should nd Me mark matic	၉	19a. Informant's Name/Relationship (Ty	ne Print)	19h Mailin	nn Address (Street	and Number or Ru			Town State 7	Zin Codo)		
nd 2 sulth ar		Charles L.Arneson				apiro Dri		-				
s 1 a if Hea		20a. Method of Disposition	20b. P	ace of Disno	sition (Name of matory or other pla		Date 16,200		tion - City or			
Page nento nt: If		14 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			uly l Cemeter				M 1 1		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Health and House and Hilled at Once.		21. Signature of Funeral Service Licens		22	2. Name and Addre	ess of FacilityLee	Funera	1 Home	Tnc 6	e, Maryland		
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/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						lyear		
Lxammer	-	Sequentially list conditions, if any, leading to immediate		anac of).						1 gen		
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be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
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h cer endin use	N/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregna 1□Live birth 2□Fetal		Te			230	d. Date of deli	ivery		
deat	sicia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at time of de		]Ectopic pregnanc ]Other <i>(sp</i> ec <i>ify)</i> _	у			Month	Day Year		
that the de ned by the a	گر چ	9 ☐ Unknown										
The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the laws.	b	Part II. Other significant conditions con	tributing to death but not resu	Iting in the ur	nderlying cause giv	en in Part I.				the cause of death?		
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	Sol						perfo	2 No	death? 1 ☐ Yes	2□ No		
nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:		t 3DDOA Oth	26. Place of Dea	th (Check only o	ne)				
Phys r this	 10	1 ☐ Yes 2 No F	1 ☑ Inpatient 2 ☐ I	ER/Outpatien 28b. Time of	1 3 DOA	4 □ Nursing H	ome 5 ☐ Resident			cify)		
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	gal	29a. Certifier  (Check only  2 Medical Exami	sician: To the best of my knowner: On the basis of examinat	wledge, death	occurred at the ti	me, date and place	, and due to the	cause(s) ar	nd manner as	stated.		
the H iin 24 the F	ledical	One)	and manner stated.	ion and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and pi	lace, and due	to the cause(s)		
To To	Σ	29b. Signature and title of certifier	11.	)	29c. Licens	e number		29d. Date s	signed (Monti	h, Day, Year)		
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5		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, I	Print)	#n.A	Chil			*18F		
Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signar	ture	aus ra	, "JUI",	CIALLS	/ II , N	1a 2	0725		
Registr	-	JUL 1 2 2007	Alexand St.	Both	Es							

rnice Adams	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No.										
Physician/ edical Examiner	1. Decedent's Name (First, Middle,Last) Larnice Adams		2. Date of Death Month Da July 9, 2007		Time of Death 0723 hrs						
)	4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Death	July 9, 2007	4c. County of Death							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Fakoma Park  If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(M	Montgomery  MM/DD/YYYY) 9. Birth	Washingto						
	3 / 8 - 9 6 - / 4 / 2   1   M 2   F   4 4   Yrs.   Usual Residence of Decedent		07-08-	1963   Cour	itry) DC						
nd show any ice.	10a. State DC 10b. County 10c. City, Town or Location Wa	shington		10d. Inside City Li 1 Yes 2							
the Maryland a or 28a-f sh tified at one Director	102 Orges Maryland Ave. NE #106	0f. Zip Code 20002	.10g.	Citizen of What Countr USA	y?						
r death with the Maryland or items 23a or 28a-f show any must be notified at once. Funeral Director	1 Armed Forces? If Yes	Decedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto F		14. Race - America White, etc. B1	an Indian, Black, ack						
rs after oural", o	3 Widowed 4 Divorced If Yes, Give Year 1 Y	es 2 No specify:  Usual Occupation (Give kind of wo	ork done 116	Specify: b. Kind of Business/Ind							
and 2 should be filed within 72 hours after and 2 should be filed within 72 hours after teath and Mental Hygicine.  tem 27 is marked other than "natural"; traumatic event, the Medical Examines To Be Completed by F	College (1.4 or 51) during mos	of working life. DO NOT use retire etary		Private							
21215-0036 Muld be filed within 7 Mental Hygiene marked other than e event, the Medica FO BE COMPIE	17. Father's Name (First, Middle, Last)  Larius Adams	18.Mother's Name		-							
2121 nould be fill is marked tic event, To Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing A	Zulene	_	Dyster ber, City or Town, State, Zip Code)							
MD and 2 shot afth and m 27 is aumatic	Shanice Adams/ Daughter 874 G	orman Ave #141 ]	Laurel, N	<b>4d.</b> 20707	1						
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturial", or items 23a or 28a-1 sho injury or other traumatic event, the Medical Examines must be notified at once.  To Be Completed by Funeral Director	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State Riverdale  4 Donation 5 Other Specify:	Pk Crem. 7-1	9-07 F		, MD						
Balti Permit. Departm mports mjury c	21 Signature of Fugeral Service Licensee 22. Nar	ne and Address of Facility RON W. North Ave	_	<del>vlor II F</del>							
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the				Approximate Interval						
/Medical xaminer	failure. List only one cause on etch line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Between Onset and Death						
_	Sequentially list conditions, b										
red Insit Examiner	ignary, leading to immediate Due to (or as a consequence of):    Cruse Enter Underlying Cause   Cruse										
uted id ansit	events resulting in death) Last Due to (or as a consequence of): d.										
50, te be executed ysician and burial - transit	X AMENDED 19b per fh g869 23,27, per E, g871, 9/27	<b>7-13-07 vt</b> /07 TT									
Box 68760, e death certificate be the attending physic of for use as the bur hysician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	death 3 Ectopic pregnar		23d. Date of delivery  Month Da	ıy Year						
the death certificate the death certificate by the attending phyched for use as the Physician/M	past 12 months?  4 Pregnant at time of death 5 Othe	(Specify)			,						
D. BC I the des by the ached for	Part II. Other significant conditions contributing to death but not resulting in the unc	erlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?						
s, P.O. Be ires that the de is signed by the d be detached f			1 Yes	2 No 3 Proba	bly 4 🗸 Unknown						
Division of Vital Records, P.O. tat or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl entification: To Be Completed by P			24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of						
tal Rectian: The Bectificate hector, page: Be Com			1 <b>✔</b> Yes 2	No 1 ✓ Yes	2 No						
Vital ysicians his certi director	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient	26.Place of Death (Check of Doal Other) Nursing		sidence 6 Other:							
n of \ ing Phy After th funeral on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how	injury occurred							
Sior Attend r death. ector: by the J	Accident Investigation 28e. Place of Injury - At home, farm, street,	1 Yes 2 No	28f Location (Stro	et and Number or Rura	al Poute Number City						
Division of Papital or Attending Physons after death.  neral Director: After the filled in by the funcal Certification: T	3 Suicide 6 Could not be determined (Specify)	ractory, office building, etc.	or Town, State		a Route Number, Oity						
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial—mans Medical Certification: To Be Completed by Physician/Medical Ex											
Me Terminal	and manner stated.  29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Mont	h, Day, Year)						
	Coma Mincerdina.D.	O.C.M.E.	J	luly 10, 2007							
		enn Street, Baltimore, MI	21201								
State	31. Date filed (Month) (May Year 2007 32. Legistrar's Signature	e.			-,						
Registrar 2001 OHMH 17 Rev											
17 Kev 1/2001	ORIGINAL										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician 6:20 Tyrone PM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Unde Months 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland Hours Days Min. NAM 2□F 7-54-164 0 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☑Yes 2 ☐ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 06 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **☑** No 1 ☐ Yes 2 ☐ No Specify. 0 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OFFICE 11/ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brown Rendallstown, md. S -iberter Tyricia - coughlor 16 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methød of Disposition 1 ☑ Burial 2 ☐ Cremation 3 FRemoval from State 4 ☐ Donation / ☐ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility redHILTON Pasa neral Home Baeto, md 21229 23a. Part. En The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 🗌 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 45/M 200 /Medical W 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) Social Security Number 7. Rge (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Months 243-26-1078 Usual Residence of Decedent Director MARCH 27, 1922 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 DYes 2 □ No Completed by Funeral Director Mil AlTimon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21 20 U.S.A or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ Mo BIACK Specify: 3 ₩ Widowed 4 Divorced "natural", Year or Dates er than "nature; the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. 4 th grade 1101 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AMMIC မ Un Known 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACKSON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Aney Mem. GArdens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility AROline Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ento the conditions of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 2 No 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by has been sig ye 2 should b 3 ☐ Probably 4 DUnknown 1 ☐ Yes 2□ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed , page certificate 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No ို 1 Inpatient 6 DOther (Specify) HOSPICE 2 ER/Outpatient 3 DOA Director: After this in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Eutaw St Baltimore, Iso MD tospice 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 12 2007 Registrar

			1 - State Amend 10a-c Registrar	State of M , 10e-f, 12, per	laryland / Depa FD, 0873, ලුවු	artment of He	ealth and M Death		iene <sub>ag. No.</sub> 007	22332	
	Physici	an	1. Decedent's Name (First, Min	ddle, Last)		Real		2. Date of Deat Month	h Day Year	3. Time of Death	
1	/Media		TATRICK	N		DK44		July !	2007	6:10fm	
	Examir	er	4a. Facility Name (If not institu	HAMEdiCAL (	enter	BA Him	-		4c. County of Dea	)/A	
	Funeral Director		5. Social Security Number 218–16–3992	6. Sex 7. A	ge (In yrs. last birthday)  83  Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 29		rthplace (State or Foreign country) aryland	
	Aaryland I show	'n	Usual Residence of Decedent  10a. State  10b. Cou	Wicomico	10c. City, Town or Lo	cation Fruit1	and			10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	or 28e-i	Funeral Director	10a Chroat and Number	5 W. Main Street	Romney	10f. Zip Code	21826	1	0g. Citizen of What C	ountry?	
	ath w	ral	317 School St	reet		26757			U.S.A.		
920	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "naturel", or Items 23a or 28e-f show injury or other treumetic event, ite Madical Examination to other treumetic event, ite Madical Examination to other treumetic event, ite Madical Examination to other treumetic event.	by	11. Marital Status  1 ☐ Never Married 2 ☒ № 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	No 43-46	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:		
21215-0036	within 72 ho ene. than "natur he Modical I	Completed		dent's Education thest grade completed)  College (1-4or	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of worki	ng	16b. Kind of Business Owned and Pat's Furi	Operated	
	filed v Hygie other t		17. Father's Name (First, Midd	(le / ast)	Tru	ck Driver	18. Mother's Name			irture	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than eumetic event, Ite M.	To Be	Edward M. Bra				Damye S				
ary	should and Men s marke turnetic		19a. Informant's Name/Relation	onship (Type, Print)	19b. Maili	ng Address (Street a	nd Number or Rura	l Route Number	City or Town, State,	Zip Code)	
	1 and 2 Health Iem 27 i	١.,	Charles Edwar	d Bray (Son)					, FL 34491		
ore	ges 1 t of H If iter or oth		20a. Method of Disposition  1  Burial 2  Crematic	on 3 Removal from State	,	osition (Name of matory or other place		in-	20c. Location - City o	r Town, State	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr once.		'4 □ Donation 5 □ Other			eral Home	7/10		Winchester	c, VA	
Bal	permit. Departr Importa eny inji		21. Signature of Funeral Servi	a Tellme		2.Name and Address 1ffin Fun .U. Box 1	eral Home	, Inc. Bridge	, WV 26711		
2	Physician		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition	or complications that cause list only one cause on each	d the death. Do not entine.	ter the mode of dying	, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death	
	/Medical Examiner	resulting in death)  Due to (or as a consequence of):									
п	Examine:	-E	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					1-244	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1						Í	
8760,	eath certificate be executed attending physician and for use as the burial-transit	Ical Exa	resulting in death) Last  Due to (or as a consequence of):  d.								
9	tificat ng phy as th										
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)		<del></del>	23d. Date of de Month	əlivəry Day Year	
Ф	quires that the de n signed by the a uld be detached t	by	Part II. Other significant cond	litions contributing to death	but not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob		to the cause of death?  Probably 4 Authorn	
Records,	0 4 0	Completed						24a. Was an autops perform	y prior to		
Vital	ician: The certificate rector, pag	BeC	25. Was case referred to med	ical			26. Place of Death			5 20140	
of V	Physician: this certific ral director,	To E	examiner? 1 Yes 2 No	Hospital: 1 Inpat	ient 2 ER/Outpatie	nt 3 DOA Othe	r: 4 Nursing Hor	me 5 🗆 Reside	nce 6 Other (Sp.	ecify)	
Division o	ling After Tune		E	stigation	ury ay Year) 28b. Time o Injury	Work	at ? 'es 2 No	28d. Describe ho	w injury occurred		
DİXİ	tal or Att	Certification;		28e. Place of Ir building, e	njury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or F i, State)	Rural Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	edical		ying Physician: To the best cal Examiner: On the basis and manner s	of examination and/or in						
	To the within 2 To the complet	×	29b. Signature and title of cent	Bio	Mi>	29c. License		2:	9d. Date signed (Mor		
6	T		- 110-	on who completed cause of	death (Item 23a) (Type,	Print) INN GRE		et Bab	timure m.D		
••	Sta Regist		31. Date filed (Month, Day, Ye	0 2007	trar's Signature	farely				-	
DH	MH 17 Rev 1/2	001			POSES SE SE	S I All Parks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** Bufill Raul Μ. July 11 3:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 267-72-9413 80 March 8,1927 Cuba Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code o e Items 23a o 931 Beaverbank Circle 21286 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23: by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 XYes 2 □ No Specify: Cuban Specify: 3 Widowed 4 Divorced White Completed the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Export Administrator McCormick & Co. Inc. 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Bufill** ၉ Jose Esther Oueral 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Towson, Maryland Olga B. Ennis Sister 931 Beaverbank Circle 21286 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot Dulaney Valley 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 7-14-2007 Timonium, 21. Si parue of Fun ra Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 and Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Month Dav Year signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an cate has l autopsy perform Yes 2 med No certificate or Attending Physician: ors after death.

eral Director: After this certification in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours a To the Funeral 6 Hospital To the I

> State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

ppleted cause of death (Item 23a) (Type, Print)

6701 N. Charles St. Forto med 21205

			for State Registrar	State o	of Marylan		rtment of H		ind M		giene Reg. No.	20117	22334	
1.2			1. Decedent's Name (First, Middle	e, Last)					2. Date of Death Month Qay Ye		Voor	3. Time of Death		
3	Physici /Medic		CHARLES	BAIL	EY					1 .	5	2007.	2.10 M	
	Examir		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or	Location of	f Death		4c.	County of Dea	th	
			NWHC				Randa					Balti		
	Funeral		5. Social Security Number 217 – 30 – 9906	6. Sex 1 <b>¼</b> M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours 2	Min.	8. Date of Birt (Month, Day	v. Year)	9. Bir	thplace (State or Foreign ountry)	
I.	Director		Usual Residence of Decedent		72	113.				3/11/	/193	5	MD	_
	land bw It		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	_
	Mary fied	ţ	MD Bai	Ltimore	G	wynn	) a k						1 ☐ Yes 2 X No	
	r 28a	Director	10e. Street and Number	LUIMOLC		w y IIII	10f. Zip Code				10g. Citiz	zen of What Co	ountry?	_
	h with		7150 N. Alter	. C+			21:	207				USA		
	deat ems	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Orig	in? (Spec	cify Yes or No-		14. Race - Ame		_
0	or ite		1 ☐ Never Married 2X Marr		2 XNo		☐ Yes 2 ☑ No	Specify:	, rueno i	iicari, etc.)		Black, Whi		
215-0036	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or D	Dates:							/	misy con	_
7	"nati	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Deced	ent's Usual Occup kind of work done o OO NOT use retired	ation during most	of workin	ng		nd of Business		
7	withir sne.	ם	Elementary/Secondary (0-12)	College (	1-4or 5+)						Be	thleh	em Steel	
N	filled Hygid ther int, th	ပ္သိ	17. Father's Name (First, Middle,	Last)		S L e	el Worke		's Name	(First, Middle,	Maiden	Surname)		_
/land	d be ental ced o	o Be	Harry Bailey	,						n Johr		ourname,		
$\mathbf{E}$	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene.  Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 25a or 28a-f show traumatic event, the Medical Examiner must be notified at the most be notified.	T <sub>o</sub>	19a. Informant's Name/Relations			19b. Mailin	g Address (Street a					Town, State.	Zip Code)	
2	alth a 27 is er trau		Julia Bailey										. ,	
aitimore,	Hei Hei tem		20a. Method of Disposition		20b. F	lace of Dispos	sition (Name of natory or other place	201	Di	ate Gy	20c. Lo	cation - City or	MD 21207 Town, State	-
Ë	Pages nent of l int: if ite	1.7	1. Burial 2 □ Cremation 4 □ Donation 5 □ Other (S				Mem. Pa		10/0	07	Arb	utus,	MD	
a	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service	Licensee /	11	22	Name and Addres	ss of Facility	WyI:	ie F/	H P	.A. 01	Balto. C	ď
n	an III	( )	Manag	o M.	104	W 9:	200 Libe	erty	Rd.	, Rand	lall	stown	, MD21133	į
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deatl	n. Do not ente	er the mode of dyin	g, such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between	ì
ę.	Physician	1	Immediate Cause (Final disease or condition	Et	Charles are	TAGE	Lymp	Hn	ma				Onset and Death	9
1	/Medical		resulting in death)	Due to	(or as a consequ		- thir	1 ( )	11/11				_	_
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100	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury	Due to	(or as a consequ	uence of):								
	ecut and I-tran	хап	that initiated events resulting in death) Last	c	(or as a consequ	ience of):								_
8/60,	icate be executed physician and the burial-transit				(or as a consequ	active oi).								
200	requires that the death certificate be executed een signed by the attending physician and rould be detached for use as the burial-transit	dical		d										
XO	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome pf pregna	incy						3d. Date of de	livan	
ă	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live	birth 2□Feta nant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)				-	Month	Day Year	
j.	the cachec	hysi	9 Unknown	9□Unkr	iown		., ,,							
T.	s thai	by P	Part II. Other significant condition	ons contributing to d	leath but not resu	alting in the un	derlying cause give	en in Part I.		23e. Did to	bacco u	se contribute t	the cause of death?	
ecords	equire en sig uld b									1 🗆 Y	es 2	XNo 3□P	robably 4 Unknown	
		plet								24a. Was a		24b. Were a	utopsy findings available	-
	sician: The law s certificate has b irector, page 2 sl	Completed								autop perfor 1∐ Yes	sy med? 2 <b>X</b> No	prior to death? 1 ☐ Yes	completion of cause of	
	ian: artifica stor, p	Be C	25. Was case referred to medical examiner?					26. Place	of Death	(Check only of		10100	25/110	-
_	Physician: this certific ral director,	10	1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	3 DOA Othe	er: 4 🗆 Nur	sing Hom	ne 5 🗆 Resid	lence 6	Other (Spe	ecify)	
0	Ing P		27. Manner of Death 1 Natural 5 □ Pending	28a. Déte (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c. Injury Work	y at </td <td>2</td> <td>8d. Describe h</td> <td>ow injury</td> <td>occurred</td> <td></td> <td></td>	2	8d. Describe h	ow injury	occurred		
VISION	tendl eath. for: A	cati	2 Accident investig 3 Suicide 6 Could r	ation				Yes 2 □ N	lo					
<u> </u>	or At ifter d Direct in by	Certification:	4 Homicide determ	ined 28e. Place build	e of injury - At ho ling, etc. <i>(Specif</i> )	ome, farm, stre //	et, factory, office		2	8f. Location (S City or Tow		Number or R	ural Route Number,	
_	pital ours a erai [		29a. Certifier 1 Certifyin	g Physician: To the	a host of my line	wledge death	opported at the time	an data an	1					
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical one)	Examiner: On the b	pasis of examina nner stated.	tion and/or inv	estigation, in my o	pinion, deat	h occurre	ed at the time,	date and	place, and du	e to the cause(s)	
	Vithin Forth	Me	29b. Signature and title of certifier	00	11.		29c. License	number	-	- 1	29d. Date	signed (Mon	th, Day, Year)	
	~		> oxramin	1 111	ella	MO	PI	1141	D		July	0514	2007.	
6	0		30. Name and address of person	who completed cau	se of death (Item	23a) (Type, I								-
_	1		MORTH WEST	Hosli	TAL	CEM	TER	RAM	0110	LS TO	Lin	MC	21133.	
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signa	ture	A. R. A.							

			For State Registrar	State of Ma	aryland / I		ment of He			F	Reg. No.	The same	22335
Ā	Physici /Medic		1. Decedent's Name (First, Middle, MABEL	BYRD	4				J	Date of Dea	3 9day 2	Year OD 7	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, Northwest Ho				. City, Town, or Randal			1		inty of Dear	
	Funeral		5. Social Security Number 6	-	e (In yrs. last bii	rthday) If	Under 1 Year onths Days	If Under 2		Date of Birt			thplace (State or Foreign buntry)
	Director		156-09-2136 Usual Residence of Decedent	1  M 2 ∠AF	94	Yrs.	Day's	riours	3	Date of Birt (Month, Day / 20/1	913		VA VA
	yland 10W		10a. State 10b. County		10c. City, Tow	m or Location	on .						10d. Inside City Limits
	e Mar	ctor	MD Balt:	imore		Pike	sville						1 ☐ Yes 2X No
	Mith th	Dire	10e. Street and Number 1840 Reisters	stown Pond	1	1	0f. Zip Code 21208				10g. Citizen	of What Co	ountry?
	Jeeth ma 234	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent of His s, specify Cubar	spanic Orig	in? (Specif	y Yes or No-			erican Indian,
တ္	or iter	Fun	1 Never Married 2 Marrie	Armed Forces?  d 1  Yes 2 1  If Yes, Give Year or Dates:	No	1	s, specify Cubar Yes 2⊠No	i, Mexican Specify:	, Puerto Rio	can, etc.)	I	Black, Whit	e, etc. rican-
9	within 72 hours after deeth with the Maryland ene. Than "netural", or itama 23e or 28e-f show the Medical Evaritinat must be notified at	d be	3 Widowed 4 □ Divorced  15. Decedent's				s Usual Occupa				16b. Kind o	Am€	rican
21215-0036	nin 72 In "ne Medic	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed)		(Give kind	of work done di IOT use retired)	uring most	of working				ŕ
ณ	Hygiene other the	Completed		College (1-4or 5	,	Scho	ol Tea					-	re hools
		9 Be	17. Father's Name (First, Middle, La Rev. John P. I				İ			First, Middle, olema		name)	
ary	should be and Mental s marked of umatic av	J.	19a. Informant's Name/Relationshi	p (Type, Print)	196	o. Mailing Ad	ddress (Street a	nd Numbe	r or Rural F	Route Numbe	r, City or To	wn, State,	Zip Code)21208
Σ.	and 2 eaith a m 27 is		Eric L. Byrd/	Son	9	Cou	rtland				Pike	svil	le,MD
סר	Pages 1 nent of H int: if ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			ry, cremator	n (Name of ry or other place Forest	7	/16/	0.7		,	Town, State
atin l	permit. Pages 1 and 2 should by Department of Heath and Menta Important: If Itam 27 is marked any injury or other traumatic av		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Galli			of Facility	7 107 ·	O/ o E/U	D V	35 M1	Dolto Co
<u>~</u>	Ded in a co		3 and Out	M.Wi	dee	920	0 Libe	rty	Řď:;	Rand	a1131	lowh,	Balt21153.
П		-	23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused nly one cause on each li	the death. Do	not enter the	e mode of dying	, such as	cardiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death
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_	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):							
3760,	death certificate be executed eattending physicien and of for use as the burial-transit	cai		d									
9 ×	eath certifica attending ph I for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy								
Вох	atten d for u	Iclan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No		2 Fetal death		opic pregnancy ner (specify)				230.	Date of de	livery Day Year
0	at the de by the a	hys	9 □ Unknown	9□ Unknown							•		
S.	The law requires that the steep state that the steep signed by the sage 2 should be detached.	þ	Part II. Other significant condition		ut not resulting i	in the under	lying cause give	n in Part I.		23e. Did to			o the cause of death?
Records,	w require been sign should b	Completed	- I telw	.113					<del></del>	24a. Was			utopsy findings available
<b>e</b>	nysician: The law his certificete has b I director, page 2 s	ошо							_	autop	rmed?	prior to death? 1 \( \sum \text{Yes}	completion of cause of
		Be C	25. Was case referred to medical examiner?						of Death (0	Check only o			-/
5		7.	1 ☐ Yes 2NO No 27. Manner of eath	Hospital: 1 inpatie		utpatient 3		4 🗀 1901		5 Resid			cify)
<u>0</u>	oteath. ctor: After y the funera	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury	28c. Injury Work 4 1 \( \text{Y}	?` es 2 □ ħ		3. D0001100 1	ow injury oc	001100	
NIS	or Attand after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of ini	ury - At home, fa c. (Specify)	arm, street,	factory, office		281	Location (S City or Tox		umber or R	ural Route Number,
			29a. Certifier 112 Certifying	Physician: To the best	of my knowledge	o doath ood	urred at the time	a data and	d place, and	d due to the		l mannor a	stated
:	To the Hospital within 24 hours et of the Funeral completely filled	Medical	(Check only   Medical E	xaminer: On the basis of and manner sta	f examination ar	nd/or investi	gation, in my op	inion, deat	th occurred	at the time,	date and pla	ce, and due	e to the cause(s)
i	To the Ho within 24 I To the Fu completel	Σ	29b. Signature and title of certifier	P m	ella	mit	29c. License					11	h, Day, Year)
/			X° A	1 17 1				•	410		JULY	,	12001.
5	٧		30. Name and address of person w	no completed cause of d		(Type, Print	10 G1	ND	EKP	ME TOWN	17 7 P.	, i	21192
É	Sta		Od Date Glad (Month Day Vane)	326Registr	ar's Signature			1414	44(-)	·	-7 - 4 V L		A11-3-1
	Registr	ar	DOL I'V	FAR SUL	U.S.	ANDRAS							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 8, 13:12 Bobby Edward Buchanan 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 12, 1937

West Virginia 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Hours M 2□F Days Min Director 232-58-7588 69 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r then "nature!, or itema 23a or 28e-f shovine Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Cooley Mill Road 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1XXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2€ No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. 12 Mill Operator Industrial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be for and Mental F Robert Crockett Buchanan Martha Kathleen Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a other t <u>Patricia V. Buchanan / Wife</u> 103 Cooley Mill Road, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Surial 2 □ Cremation 3 □ Removal from State permit. Page Department c important: If any injury or once. ō Harford Memorial Grdn 7-13-07 Aberdeen, Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Knowll 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** ONGED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OROM ) no aro if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a cons for use as the burial-transit Hischanar as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 28 No 1□ Yes → No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 P/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AR

31. Date filed (Month, Day, Year)

MO

32. pegistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4'12 PM Diane Leslie Courtman Jul 2007 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Hours 1 □ M 2 🛛 F Director 266-19-0421 53 FEB 1 1954 California Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 920 Berwick Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 Is marked other that any Injury or other traumatic event, the Nonce. 12 Medical Transcriptionist <u>Healthcare</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salage George Bertha Jung ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colin Courtman - husband 920 Berwick Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 7/11/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. permit. 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALS Physician 6 yrs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: signed by the a Be Completed by

Baltimore, Maryland 2121

Division or Vital Records, P.O. Box 68760,

	To the Funeral Director: After this certificate has	2 and a filled in hy the funeral director nade 2
ifter death.	Director: After t	in hy the funera
within 24 hours after death.	To the Funeral	completely filled

일

Medical Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		pic pregnancy er (s <i>pecify</i> )		23d. Date of delivery  Month Day Year				
Part II. Other significant conditions Chronic resp to	contributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?				
Anemio			24a. Was an autopsy performed 1 Yes 2 2 N	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ Yo				
25. Was case referred to medical		26. Place of Death	(Check only one)					
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hom	e 5 ☐ Residence	5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigati		Work?	8d. Describe how inju	ury occurred				
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		actory, office 2	Bf. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)				
29a. Certifying F (Check only one)  1 Certifying F  2 Medical Ex	Physician: To the best of my knowledge, death occ aminer: On the basis of examination and/or investion and manner stated.	urred at the time, date and place, a gation, in my opinion, death occurre	nd due to the cause( d at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)				
29b. Signature and title of certifier		29c. License number	ate signed (Month, Day, Year)					

State Registrar

29d. Date signed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print)

Smai losata

31. Date filed (Month, Day 2007 2

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** VU 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hos N/A 8. Dave of Birth (Month, Day, Year) Jan 27, 19 Birthplace (State or Foreign Country) (In vrs. last birthday Year If Under 24 Hrs. Days Hours Min. **Funeral** 1∭ M 2□ F 82 216-18-4531 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Pvlesville Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygene.
Important: If Item 27 is marked other than "natural", or Items 23a or: any Injury or other traumatic event, the Medical Examiner must be none. 21132 1730 Eden Mill Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 107.3 11. Marital Status 17 Yes 2 No 1943 If Yes, Give Year or Dates: 1946 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Principal Elementry School Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norval Carr, Sr. ပ္ Agnes Rose Coale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lynn Carr, Wife</u> 1730 Eden Mill Road Pylesville, Maryland 21132 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/12/07 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service icensee
Thomas Gregory <sup>22. Name and Address of Facility</sup> Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Mary Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ventricular hour /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 TYes 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 .10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE STREET, BALTIMORE, MD 21297 Matheliu Hansic 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

		-	For Stete Registrer	State of Maryl		artment of			iene2 () () 7 og. No.	22339
			Decedent's Name (First, Middle, Last	st)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia		Bertha Po	len	Carp	enter		July 8,		2:34 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			or Location of De	eath	4c. County of Dea	th
			Harford Memoria				De Grace		Harford	Mula a (Ctata as Fassian
	Funeral		5. Social Security Number 6. S	ex 7. Age (In)	yrs. last birthday) Yrs.	Months Day	r If Under 24 h s Hours M	frs. 8. Date of Birth (Month, Pay, NOV • 1	Veat) C	thplace (State or Foreign ountry) ginia
	Director		225-28-7175 Usual Residence of Decedent	07	110.			100. 17	, 1010 VII	611114
	land ow		10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary Fig.	to	Virginia Prince V	Villiam Ma	anassas					1 ☐ Yes 2 No
	h the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a c	Funeral Director	10700 Crestwood D		14	20109			U.S.A.	
	ems erm	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Co	f Hispanic Origin? uban, Mexican, Pi	(Specify Yes or No- uerto Rican, etc.)	14. Race - Am Bfack, Whi	
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖔 N	lo Specify:		Specify: Wh	ite
21215-0036	hour ture!	ed b	15. Decedent's E		16a. Dece	dent's Usual Occ	cupation		16b. Kind of Business	
Ċ	in 72 n " n	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work dor DO NOT use ret	ne during most of ired)	working		
212	y with	E	Elementary/Secondary (0-12)	College (1-401 5+)	Home	maker			Own Hom	е
פַ	othe othe	BeC	17. Father's Name (First, Middle, Last	)				Name (First, Middle,		
aryland	Ments Ments arked	70	Luther Jett Pat	tie				ha Jeffers		
an)	2 sho and i		19a. Informant's Name/Relationship						r, City or Town, State,  MD 2107	
2	end lealth m 27 her tr	1 2	Cathey Robertso		b. Place of Disp	Control of the Contro		Date Date	e, MD 2107 20c. Location - City o	
0	ges 1		20a, Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3  ☐	Removal from State	Sudley U	matory or other n	achodist	/10/07		
Baltimore,	t. Pa rtmen rtant: njury		4 □Denation 5 □ Other (Speci 21. Signature of Funeral Service Lice		Church C	emetery		/12/07	Cathar in,	VA
Bal	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show shy hjurry or other traumatic event, the Medical Examinar must be notified at an ance.		21. Signature of Peneral Service Lice		TO TO	iorea E	meral H	ome, Inc. Manassas,	VA 20110	
			23a. Part1. Enter the disease, or con	plications that caused the						Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause in each line.	mit	Trelia	, ,,,	1-112		nser and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a co	nsequence of);	~ 0·~	,	dow		~4.0
	Examiner		Sequentially list conditions	b. Valoul	ar h	wix	lueas	Ü		
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
	ecute and trans	Examine	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):					
8760,	ate be executed only sicien and the burial-transit				,					
	physicate s the	dic		d						
Box 6	death certificate e attending phys d for use as the	N/S	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of d	
ă	death a atter	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		□Ectopic pregna □ Other (specify			Month	Day Year
P.O.	t the by th ache	Physician/Medicai	9 ☐ Unknown	9□ Unknown						
		by P	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause	gwenin Part J.			to the cause of death?  Probably 4 Unknown
Records,	The law requires ste hes been sign page 2 should be		1 Courters	small )	cower 100	1 OUGH	Juan	יםי יעמ		
ecc	e law r hes be je 2 sh	Completed	Chronia al	real fil	rula	un-		24a. Was	an 24b. Were prior to rreed? death	autopsy findings available completion of cause of
= E		S	Tulmonary	interser	tial f	ibros	w ·	1 ☐ Yes	2 No 1 □ Y	
Vital	Physicien: 1 this certifice ral director, p	8e	25. Was case referred to medica examiner?	Hospital:		)	Othor	Death Check only o	2.77	
ot	Phys this raldia	은	1 ☐ Yes 2 No 27. Manner of eath	1 X Inpatient	2 ER/Outpatie		njury at Work?	<del></del>	dence 6 Other (Si	Decity)
on	ding h. After fune	ţ	1 Natural 5 Pending	(Month, Day Ye	na <i>r)</i> Injury		Work? 1 ∐ Yes 2 ∐ No	,		
Division	f or Attending efter death. Director: After I in by the fune	fica	3 Suicide 6 Could not	be 28e. Place of Injury	- At home, farm, s	street, factory, off	ice	28f. Location (S City or Tox	Street and Number or	Rural Route Number,
á	2027	Certification:	4 Homicide	building, etc. (S	<i>вресну)</i>			S., y c., 10.		
	To the Hospital of within 24 hours of To the Funeral D completely filled in		29a. Certifier Check only 2 Medical Ex	hysician: To the best of mariner: On the basis of ex	y knowledge, deamination and/or	ath occurred at th	e time, date and p	place, and due to the occurred at the time.	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	the Hin 24 the Fi	ledical	one)	and manner stated			cense number		29d. Date signed (Mo	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	Brish &	M /	Sac. Fig	N 2/9	40	TULY &	2007
	Ta		- Tura	1 smil	1-64	7 - DO	END LA	LEMORIL	MACALON	3015.
1	20		30. Name and address of person wh	completed cause of death	r(item 23a) (Typ	e, Print) MAN	HAVR	_		21078
	Ç.	ate	31. Date fifed (Month, Day, Year)	32 Registrar's	Signature	MOE	/ T/ TV / C	U	J	
	51	ate		2007	16 1	madel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ju Month ľΫ **Physician** 2007 12:40 ам Mary D. Canedo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Timonium Stella Maris 8. Date of Birth Dec. 30, Year) 929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours New York 1□M 2**X**F 77 Yrs. 131-26-6370 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Iem 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b County 10c, City, Town or Location 1 ☐ Yes 2 X No Timonium Baltimore Directo Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21093 600 Straffan Drive #102 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Own Home Homemaker 18. Mcther's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret S. Smith Dr. Richard T. Darby ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Alfred E. Canedo/ Husband 600 Straffan Dr. #102 Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-16-07 Towson, Md. Hilltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility Uneral Home, Ruck Towson Funeral Home, 1050 York Rd. Towson, Md.</sup> 21. Signature of Funeral S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mentio /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-trar Due to (or as a consequence of) the attending physician hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by page 2 should be 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2전 No 24a. Was an has autopsy performe 2X No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA Medical Certification: To 1 🔲 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 ERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- State Amend PI, line b-c, perMD, g869, 7/12097tHicate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Edward M. Collins 12:46 P M June 30 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept. 13 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Year Days **1**□ M 2□ F Sept. 219-18-5621 84 Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r USA 21093 2416 Girdwood Rd. Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner mu 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married Married 1 ☐ Yes 3 € No Specify Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dir. of Material Management Balto. City Government 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Howard L. Collins Eva S. Wrightson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2416 Girdwood Rd., Timonium, MD 21093 Mary E. Collins/wife Department of Health Important: if Item 27 any Injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/6/07 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Si Vice of Funeral Sev ca bige of Michael J. Fla 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Due to (or as a consequence of): Aspiration pneumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a. Was an page 2 autopsy performed' certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Hospital or Attending 24 hours after death. 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide n 24 hours after de le Funeral Directo eletely filled in by t 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) stret Towen, MD Allison trubai GBMC 6701 N. (honles 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	-	Certificate			-	glerie Reg. No.	and the same of th	0901.0
13	Dharaini	10.0	1. Decedent's Name (First, Middle, Last	)					Date of De     Month		Year	3: Time of Death
	Physicia /Medic	_	William W.	Corb	ett				Ju1y		007	1:40AM M
	Examin	er	4a. Facility Name (If not institution, give	street and number)			vn, or Location			4c. County of		1 1
3		4	3740 Line Drive 5. Social Security Number 6. Se	7 400	(In yrs. last bir		cheste		8. Date of Bir		arro.	LL place (State or Foreign
ü	Funeral Director			MM OFF			ays Hours	Min.	(Month, Da	iy, Year) 11,1928	Coul	mtry) MD
	land ow t		10a. State 10b. County		10c. City, Town	or Location					1	10d. Inside City Limits
	Mary -f sh	ğ	MD Carrol	1	Mano	chester						1 □Yes 2X No
	n the r 28a	Director	10e. Street and Number		110111	10f. Zip Co	de			10g. Citizen of W	hat Cour	ntry?
	th wit		3740 Line Drive				21102			US	SA	
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Deceden	t of Hispanic C Cuban, Mexic	origin? (Spec an, Puerto F	cify Yes or No Rican, etc.)	14. Race Black	- Americ c, White,	can Indian, etc.
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	0	1 □ Yes 2 <b>X</b>	No <i>Specif</i>	iy:	_	Specify:	Wh:	ite
2	72 h 'natu dical	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. 	Decedent's Usual C (Give kind of work of	lone durina ma	ost of workin	g	16b. Kind of Bus	siness/In	dustry
7	vithin ne. han '	dm	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Sargean	,			Dolt Co	~	. Dolina
, D	filed v Hygie ther i								(First, Middle	Balt. County Polic First, Middle, Maiden Surname)		
au	ould be the Mental I arked or atic eve	To Be	Joseph Robert Cor		Mary Byrne							
Ž	2 should and Mer Is marke aumatic	F	19a. Informant's Name/Relationship (T		19b	. Mailing Address (S	Mary Byrne  ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code,					o Code)
Š	1 and lealth em 27 ther to		Georgia Corbett	Sister in	Law 37	740 Line I	rive,	Manche	ester,	MD 21102	2	
re,			20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐		20b. Place of cemete	Disposition (Name ry, crematory or other	of er place)	Da	ate	20c. Location - 0	City or To	own, State
E	Pages nent of hant; If Ite		1 ☐ Burial 2 ☐ ACremation 3 ☐ III		Carro	11 Cremat:	Lon	7/12	/07	Hamps	stea	d, MD
att	permit. Departr Imports any Inju		21. Signature of Fuperal Service Licens	000	2.	22. Name and				4 Reiste		
<u> </u>	8 Q E # 9		Jul 8 A	500		Eline F				terstown	, MD	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused to one cause on each line	the death. Do i	not enter the mode o	f dying, such a	as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Product Culcet  3/24/04 >7/////									
E.	Examiner		Due to (or as a consequence of):									
	· A.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a	consequence	of):					-	
	uted d ansit	Cause (Disease or injury that initiated events c.									3	
Ó	eath certificate be executed attending physician and for use as the burial-transit	resulting in death) Last  Due to (or as a consequence of):										
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	ertific ling p e as f		IF FEMALE:	20- 16		1000						
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o.	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	by Physician/№	1 □ Yes 2 □ No 9 □ Unknown	2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)								
<u>α</u>	that the	V Ph	Part II. Other significant conditions co	ontributing to death bu	t not resulting in	n the underlying cau	se given in Par	t I.	23e. Did	tobacco use contr	ibute to f	the cause of death?
rds	quires n sigr	q p							1 🗆	Yes 2 No	3 ☐ Pro	bably 4 Unknown
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æ	The la	mo							auto perfe 1□ Yes	ormed? d	leath?	ompletion of cause of 2 12 No
ita	fan: artifica stor, p	Be C	25. Was case referred to medical examiner?				26. Pla	ce of Death	(Check only			
<u> </u>	hysic his ce I direc	70 E	1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2□ER/Ou	·		Nursing Hon	ne 5 D Res	idence 6 🗆 Othe	er (Speci	ify)
n o	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day			. Injury at Work?		28d. Describe	how injury occurre	ed	
sio	tendi leath. tor: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		n. Akkama fa	M	1 ☐ Yes 2		Of Leasties	(Chun at a m of Alicente	C	m I Davita Alumbar
Division or Vital Records,	or At after of Direct in by	Certification:	4 ☐ Homicide determined	building, etc		arm, street, factory, o	illice		City or To	(Street and Numbe wn, State)	er or mur	ai noute Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Co	29a. Certifier 1 Gertifying Phyone 2 Medical Examone)	ysician: To the best on the basis of and manner star	examination ar	e, death occurred at nd/or investigation, in	the time, date my opinion, c	and place, a death occurre	and due to the ed at the time	e cause(s) and ma , date and place, a	nner as	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and mainter sta		29c. L	icense numbe	r		29d. Date signed	(Month	, Day, Year)
	- 5		De Calt	loo lann	0/11		6459	7		7/11	10	7
ا الريا	41		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)	01 - 1	<u> </u>		////		
10	71 1		555 S. Center S.	t. Westm	inster.	mo 211:	57					
	Sta		31. Date filed (Month, Day, Year)		ar's Signature							
	Regist	ar	JUL 12 2007	Deall page	A. A.	new (A)						

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**O**RIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Callahan, Arthur В. 2007 6:00 a July 10, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Futurecare Cherrywood Reisterstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2 □ F Aug. 8, 1913 VA Director 93 212-01-4339 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Reisterstown MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 U.S.A. 30 Caraway Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 3 any injury or other traumatic event, the Medical Examiner muonge. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: White <u>ک</u> 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager McComas & Sons 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Alice Ficklin Callahan, Sr. ို Arthur B. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 Reisterstown, MD BO Caraway Road Sharon G.\_Callahan Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkville, MD Moreland Mem. Park 7/13/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road hor m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onsevand Death Immediate Cause (Final disease or condition resulting in death) Physician In hum verne /Medical Due to (or as a consequence of): Sequentially list conditions, if any, loading to infinitelliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 7 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, attending physician for use as the burial signed by the a d be detached for this After t 124 hours after death.

In Funeral Director; A sletely filled in by the fu

death with the Maryland

Baltimore, Maryland 21215-0036

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within 2.

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State

Medical

6 ☐ Could not be

Year)

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

30. Name and ad ress of

31. Date filed (Month, Day,

29b. Signature and title of dentifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Greene Tree Rd

29d. Date signed (Month, Day, Year)

11010

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

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State

Registrar

12

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death T. Ju<sup>M</sup><sup>™</sup> 5, 2007 Year **Physician** Wilson Dobbins 3:23 pm /Medical 4a Facility Name (If not institution, give street and number)
Joseph Richey Hospice 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 7 (Mov 9 Day 9 Pa 9. Birthplace (State or Foreign County) 5228-07-7795 6. Sex 1 M 2 ☐ F 7. Age (In yrs last birthday) **Funeral** Director Usual Residence of Decedent 10c. City, Town or Lpcation
Owings 10d. Inside City Limits 10a. State MD Baltimore 28a-f show Mills 1 Yes 2 No ral", or items 23a or 28a-f sh Examiner must be notified Directo 10f. Zip Code 10g. Citizen of What Country? 4504 Lyons Run Circle #101 USA 21117 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1944— 1 1 Yes 2 No 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 Specify. 3 ☐Widowed 4 ☐ Divorced Specify. Year or Dates: 'natural" Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Gov't Elementary/Secondary (0-12) College (1-4or 5+) Security Health and Mental Hygiven 27 Is marked other other traumatic event, till 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry George Dobbins Roberta Irby ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 I 4817 Dalton St. Temple Hills, MD 20748 Henry Dobbins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot once. I Burial 2 ☐ Cremation 3 ☐ Removal from State 07/14/07 Blackstone, VA Green Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 108 W. North Ave. Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or a a consequence of): cancer an known /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 Other (specify) has been signed by the a ge 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Nonknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate ha autopsy performed funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 1 Tes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Jr At.
Jes after deau.
Jest Director; A.
Jest by the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

+1

15/15

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Evitanst Bultimore MD 21201 838 tospice

gistrar's Signature

07-05244
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Robert Stanley Durden

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ease	Type of Fills in Die	ack indelible lik.	Fliante VII Cobica Vic	
	State of Maryland /	Department of He	ealth and Mental Hygiene	,

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	1- For State Registrar	Cert	tificate of Death	Reg	No.
Physician/ ledical Examiner	Decedent's Name (First,     Rot	pert Stanley Durden		July 8, 2007	
<b>3</b> 4, <b>6</b> 5,	4a. Facility Name (if not ins 4104 Duane Aver	stitution, give street and number)	4b. City, Town, or Locat Batimore	- · - · - ·	4c. County of Death N/A
Funeral Director	5. Social Security Number 214-94-7341	6. Sex 7. Age (In yrs. lat	"	Under 24Hrs. 8. Date of Birth lours Min. Jun. 1	(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington County)
daryland 28a-f show any 1 at once.	Usual Residence of Deced  10a. State  MD		Town or Location Pasadena	= 3.7	10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f sho tified at once.	10e. Street and Number 45 Luke Driv	<i>7</i> e	10f. Zip Code 2112		Citizen of What Country? United States
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she sevent, the Medical Examiner must be notified at once or the Natural Examiner sevent or Second Sec	3 Midowed 4	Married  12. Was Decedent Ever in U.S  Armed Forces?  1 Yes	5. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	cican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
0036 within 72 hours after giene. her than "natural", Medical Examiner ompleted by		n (Specify only highest grade completed)  (0-12) - College (1-4 or 5+)	16a. Decedent's Usual Occupation (C during most of working life. DO I	NOT use retired)	16b. Kind of Business/Industry
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical To Be Comple*	17. Father's Name (First, in	·		other's Name (First, Middle, Ma	Diesel Trucks aiden Surname)
2121 ald be fill Mental I marked event,		E. Durden (Type, Print )	19b. Mailing Address (Street and	Deanna Dodd I Number or Rural Route Numb	per, City or Town, State, Zip Code)
MD of 2 shot of 2 shot of 2 shot of 27 is a aumatic	Suzette Lema	aster - Sister	1614 Popland St	treet, Apt. 1,	Curtis Bay, MD 21226
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Maring or other traumatic event e	20a. Method of Disposition  1 Burial 2 X Cre  4 Donation 5 Ot	mation 3 Removal from State	Place of Disposition (Name of cemeter grate Arginchede) Crematory	7-12-2007	20c. Location - City or Town, State  Odenton, MD
Balti permit. Departi Importi injury o	21. Signature of Funeral S	me Commence	2719 Hammonds	s Fry Rd., Lan	eral Home, Inc. sdowne, MD 21227
Physician Medical (aminer	23a. Part I. Enter the disea failure. List only one Immediate Cause (Final d	Annhunia	Do not enter the mode of dying, such	as cardiac or réspiratory arres	st, shock, or heart Approximate Interval Between Onset and Death
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vecuted 1 and - transit		Last Due to (or as a consequence of	f): 		
ial ial	UNPENDED  IF FEMALE:	AMENDED  23c. If yes, outcome of pregr	nancy		23d. Date of delivery
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of Vital Records, ng Physician: The law requires the this certificate has been signered director, page 2 should be not To Be Completed				autops perform 1 🗸 Yes 2	med? death?
tal Reccian: The certificate ector, page		medical	26.Place of D	Death (Check only one)	
F Vital Physician r this certi	examiner?	No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	·taromy rome	Residence 6 Other: Scene
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Division o Spital or Attending spital or Attending nours after death. neral Director: Aft filled in by the fune	3 V Suicide 6 Homicide	Could not be determined (Specify) Townhouse	ome, farm, street, factory, office buildi e / Rowhouse	or Town, St	treet and Number or Rural Route Number, City (ate) venue, Baltimore, MD
Divis  To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in E		ying Physician: To the best of my knowled cal Examiner: On the basis of examination a and manner stated.	ge, death occurred at the time, date a and/or investigation, in my opinion, dea	and place, and due to the cause ath occurred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
- F. 2 E. 8   A	29b. Signature and title of		29c. License nu O.C.M.E		29d. Date signed (Month, Day, Year) July 9, 2007
47	30. Name and address of Melissa Brassell	person who completed cause of death (Item, MD Assistant Medical Examin	ner 111 Penn Street, Balti	more, MD 21201	
Stat Registra		(,Year) 32. Registrar's Signatu	ura partir		

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ July 5, 2007 0524 hrs Medical Examiner Dirubbo Mark Peter 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital **Baltimore** If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Min. Country) Director Mar. 7, 1956 MA 017-46-6150 1 XM 2 51 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 X Yes 2 No Baltimore 28a-f shov MD notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 21234 2504 Moore Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? Never Married 2 Married 1 X Yes ō Specify: White es, Give Year Yes 2 X No specify: within 72 hours after 3 Widowed 4 X Divorced other than "natural", 1976 ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 Electronics 4 Purchaser 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, the Beatrice L. Rochette æ Peter A. Dirubbo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD 1723 Maple Avenue, Hanover, MD 21076 Stephanie Dirubbo/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7-11-2007 Lowell, MA Patrick Cemetery St. Donation 5 Other Specify 21 Signatur of Funeral Service Licen 26 22. Name and Address of Facility Dolan Funeral Home 106 Middlesex St., Chelmsford, MA 01863 men 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ian/Medical X UNPENDED AMENDED 7, perME. g870, 8/15/07 TT the attending physician ed for use as the burial -Applyision of Vital Records, P.O. Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Month Live birth Fetal death past 12 months? Pregnant at time of death Physicia Other (Specify) signed by the atter be detached for u 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ۾ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ✓ Inpatient 2 Other<sub>4</sub> Other Nursing Home 5 Residence 6 DOA ER/Outpatient 3 this 1 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Medical Certification: 1 X Natural 1 Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 21 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific July 6, 2007 Mup O.C.M.E 0 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

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DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7, 2007 William M. July 10:15 AM Dunlap /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1**X** M 2□ F 230-32-6752 77 1, 1930 Virginia Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 21 No Director Maryland | Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9002 Anna Drive 20735 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 TYYes 2 □ No If Yes, Give Year or Dates Korea 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Householder Lena Cave ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9002 Anna Dr., Clinton, MD 20735 Shelby Crouse Dunlap (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 Other (Specify) Mt. Hebron Cemetery 7/11/07 Cross Junction, VA 22. Name and Address of Facility Giffin Funeral Home, Inc. P.O. Box 100 Capon Bridge, VA 26711 21. Signature of Funeral Service Ligensee. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician 4 ERC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner iastalie attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obstructive 1 Yes 2 No 3 Probably 4 Unknown Drovexia 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 [ No 28a. Date of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Akim mo

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State Registrar Solomons

Island Road, Hyntingtonn, MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. #egistrar's Signature

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kathryn L. July 10, рМ Deem 2007 8:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2\□ F Days Hours 234-30-0514 88 Director 10,1919 Jan. W.V. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Dundalk Directo Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3402 Louth Rd. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes X☐ No <u>ک</u> Specify: White 3√ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. <u>Housewife</u> Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Logue Edna G. White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Deem 359 Crane Hill Al 35053
Date | 20c. Location - City or Town, State 507 County Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 14 4 Donation 5 Dother (Specify) Baltimore Oak LAwn Cem. gnature of funeral Service 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 7110 Sollers Point Rd. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hosping...

within 24 hours after death.

To the Funeral Director: After this commistely filled in by the funeral director.

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al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury) that initiated events resulting in death) Last	b. Due to (or as a consect  Due to (or as a consect  Due to (or as a consect	,				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 Live birth 2 Fet 4 Pregnant at time of 6	al death 3 □Ectopic pre			23d. Date of de Month	livery Day Year
ed by Pr	Part II. Other significant conditions of	ontributing to death but not res	culting in the underlying cau	ıse given in P <i>ar</i> t I.			o the cause of death? robably 4 □Unknown
					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
o Be	25. Was case referred to medical examiner?	Hospital:	]ER/Outpatient 3 ☐ DOA	Othor	ath Check onl one	0.750	1/- 1/2
Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred				
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory,	28f. Location (Street City or Town, Sta	Location (Street and Number or Rural Route Number, City or Town, State)		
Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurred at ation and/or investigation, i	t the time, date and place n my opinion, death occ	ee, and due to the cause curred at the time, date a	(s) and manner a	s stated. e to the cause(s)
ME	29b. Signature and title of certifier	7 Nily.		License number	29d. [ J_(	Date signed (Mon	th, Day, Year)
	30. Name and address of person who	completed cause of death (Iter Bin C 676	n 23a) (Type, Print) ) (	arle St.	Balto m	42120	>

State Registrar Date filed (Month, Day, Year)

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Physician James J. Demos July 9 4:25 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lutherville Baltimore Co. Heart Homes of Lutherville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 11-01-1910 Massachusetts 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days **XX**M 2□ F 131-07-3581 96 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1XXes 2 No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 21218 USA th and Mental Hygiene. 7 Is marked other than "natural", or items 23a traumatic event, the <u>Medical Examiner must b</u> 3900 N. Charles Street Apt. 1007 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1选Mes 2□No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Translator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vasilikie Angelopoulos John Demetropoulos ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 N. Charles St. #1007 Baltimore, 21218 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 is other tra (Wife) 3900 N. Charles St. #1007 Catherine Demos 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 7/12/2007 Catonsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211 M80891 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final obstructive lung disease Physician Chronic ears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown Year Dav 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No page 2 s autopsy perform 2 🗖 No after death. | Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death Certification: 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide determined

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica filled in by

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rile Balto und 6701 Nle-31. Date filed (Month, Day, 32 Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) A M Month DEVESE 0 2007. LEAMOR 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Randallstown Northwest Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 □ M 2XX 83 Yrs 213-38-6381 Dec. 3, 1923 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h County 1XXYes 2□No Maryland Carroll Eldersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21784 2012 B Rudy Serra Drive America of 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ②XNo if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Specify: White 3XXVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Katherine Prucha Karl Otto Seiser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon F. Devese (Son) 2500 Foxtail Court; Hampstead, Maryland 21074 July 11, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial ACCremetion 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 2007 Catonsville, Maryland 22, Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Funcial Service Library avn 3296 Charmil Drive; Manchester, Maryland 21102 Part . There the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. I nmed ate Cause (Final diagram e or condition resulting in death) ASPIRATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Year 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 (No 24a. Was an autopsy performed? Yes 2D No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 📆 No 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Feath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

that the death certificate be executed P.O. Box 68760. Division or Vital Records,

**Physician** 

/Medical

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**Funeral** 

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29a. Certifier

(Check only one)

29b. Signature and title of certifig

Pages 1 and 2 should be

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Baltimore, Maryland 21215-0036

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Medical

State Registrar

Registrar's Signature

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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JULY 10th 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITA ENTER 31. Date filed (Month, Day, Year

> 2007 9

JOGINDER P MEHTA

RANDALLSTOWN

Baltimore. Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene

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	deatl e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at time o		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	y 		Mont	h	Day Year
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ر. ص	s tha ned l		Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to th	e cause of death?
δ	quire n sig ald b	d b						1 □ Y	es 2 No 3	Prob	ably 4 □Unknown
8	w require been signatured should b	Completed by						24a. Was a	an 24b. W	ere autor	psy findings available
Re	he lav e has ige 2	ᇤ							med?// de	eath?	psy findings available mpletion of cause of
a			25. Was case referred to medical				00 51 15 11			Yes	2□ No
or Vital Records,	Physician: The Is this certificate har al director, page 2	Be	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	26. Place of Deat				
0	- E	- T	27. Manner of Death	28a. Date of Injury	28b. Time o	IL OLI DOX	4 LI Nursing Ho		lence 6 COther		10SPICE
27. Manner of Death  27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury at Work?  1							and any occurren	-			
S	Attending r death. ector: After y the fune	ical	3 Suicide 6 Could not be		home, farm, st			28f, Location /S	Street and Number	r or Rura	l Route Number
Division	1 # fb c	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)	, 2.0.,, 0.1100		City or Tow	n, State)	o. riura	
_	Hospital of 24 hours at Funeral Detely filled i		29a. Certifier Certifying Ph	ysician: To the best of my k	nowledge, deat	h occurred at the ti	me, date and place	and due to the	cause(s) and man	ner as si	tated.
	24 h 24 h Fun	dical		niner: On the basis of exami							

29c. License number

ORIGINAL

29d. Date signed (Month, Day, Year)

State Registrar

Me

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per dose 869 7 12 107 Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 8 Day 3. Time of Death **Physician** 10:28 a<sup>M</sup> July 2007 Laimons Eglitis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8 Arbutus Avenue Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV 15 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 173-26-6938 Director Latvia Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b 8 Arbutus Avenue 21228 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor of Fine Arts Higher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fricis Eglitis Elizabeth Pauzers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gunta Eglitis - wife 8 Arbutus Avenue, Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 7/10/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myocardial intarction /Medical Examiner Viterioscherotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed 4 pertension attending physician and for use as the burial-tran Do to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 □ Yes denocarcinoma 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury Natural 1 □ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director; completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital ኬ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

30., Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gallager

716

- MO

32. Registrar's Signature

Marper Choice Lane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Day **Physician** Ervin 2007 4:05a Sylvia 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2√2 F 213-54-1950 60 Director 6-24-1947 Md Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f sh t be notified Baltimore NA Director Md. 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21217 USA 1506 Presser Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ No If Yes, GiveX Year or Dates: ō 1 ☐ Yes 🍇 ☐ No Specify. Specify: Black ò 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) is marked other than raumatic event, the M Own Home Homemaker 8th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mobley Ervin, Sr. Equlear Robert မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 Presser Ct., Baltimore, Md. James I. Smith Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Baltimore, Md. Greenmount Cem. 7-12-07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East Brown Millar 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UIAMENC NEChropathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page certificate 1∐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify No Spile) ပ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Hospital or Attending 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No thours after death.

-uneral Director: A
ely filled in by the fu investigation death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Dercertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

harles of Bowen MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For State Registrar	lease				/ Depa		Health and I Death	Mental Hyg	•	Die.	22355
Physicia	: in	Decedent's Name (First,  Robert	Middle, Las		ans					2. Date of Deat	D-11	Year	3. Time of Death 9:30 A M
/Medic Examin		4a. Facility Name (If not ins	titution, give	e street and n	umber)				or Location of Death	•	4c. County	of Death	
Funeral Director		5. Social Security Number 216-32-5652 Usual Residence of Deceding	16-32-5652 1♥ M 2□ F 72 Yrs. Months Days Hou						If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 28,	<sup>Year)</sup> 1934	9. Birthp Cour Mai	olace (State or Foreign http: 'yland
aryland show d at	_	10a. State 10b. C	County		100		own or Lo					1	0d. Inside City Limits 1 1 Yes 2 No
the Ma 28a-f	recto	MD  10e. Street and Number	n/a				altim	10f. Zip Code		110	0g. Citizen of	What Cour	
ath with	ralDi	119 E. Nort	hern	Parkwa	ıy			21 21			U.S		
urs after des al', or items Examiner m	by Funeral Director	11. Marital Status  1 ☑Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		Armed	aive No	in U.S.	- 1	Vas Decedent of If Yes, specify Cub  ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ ck, White, y: Шhi	etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. De (Specify only Elementary/Secondary (I		de completed	(1-4or 5+)	-	(Give life. L	ent's Usual Occu kind of work done OO NOT use retire	pation during most of wor ed)	king	16b. Kind of B		dustry
ould be filed Mental Hygi arked other atic event, tl	To Be Co	17. Father's Name ( <i>First, M</i>							18. Mother's Nan	ne (First, Middle, M	Maiden Surnai	,	yman
nd 2 sho alth and 27 is ma r trauma		19a. Informant's Name/Re John T. Eva							and Number or Ru orest Ct				, MD 21093
Pages 1 arment of Hearmint: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crem 4 ☐ Donation 5 ☐ O						sition (Name of natory or other pla ETV COT	7/1	Date :	20c. Location		own, State
permit. Departn Imports any inju		21. Signature of Funeral S						1050 Yo	ess of Facility Ruc ork Rd.,	towson, M	1D 212		me, Inc.
Physician /Medical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or/as a consequence of):  Interval Betw. Onest and D. The condition of the									Approximate Interval Between Onset and Death			
te be ysicia ie bur	dical Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c	o (or as a co								
at the death certificate by the attending phy tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 🗆 gnantattime	Fetal de	eath 3	Ectopic pregnand Other <i>(specify)</i> _	sy			ate of deliver	ery Day Year
w requires that been signed b should be deta	ò	Part II. Other significant c	onditions c	ontributing to	death but no	ot resultin	ng in the ur	derlying cause gi	ven in Part I.	23e. Did tob		tribute to th	ne cause of death? eably 4  □Unknown
The law ate has b page 2 sl	Completed	05 W									ned?		psy findings available mpletion of cause of 2⊠No
di isi	To Be	25. Was case referred to n examiner? 1 ☐ Yes 2 ☑ No	nedicai	Hospital: 1	] Inpatient	2 ER	l/Outpatien	3 DOA Ott	hor:	th (Check only one ome 52 Reside		ner (Specif	iv)
ding Ph h. After th funeral			Pending	(Mc	e of Injury onth, Day Yea		Bb. Time of Injury	28c. Inju Wo	ry at rk? ]Yes 2 □ No	28d. Describe ho	w injury occur	red	
To the Hospital or Attending Pl within 24 hours after death, To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ 0	nvestigation Could not be determined	28e. Plac	ce of injury - ding, etc. (S	At home pecify)	e, farm, stre	eet, factory, office	Tes Z No	28f. Location (Sti City or Town		per or Rura	I Route Number,
he Hospita in 24 hours he Funera pletely fille	Medical C	29a. Certifier 15≰ Ce (Check only one) 2 ☐ Mo	ertifying Ph edical Exan	niner: On the	ne best of my basis of exa unner stated.	y knowle imination	edge, death n and/or inv	occurred at the t restigation, in my	ime, date and place opinion, death occu	e, and due to the ca	ause(s) and m ate and place,	anner as s and due to	tated. o the cause(s)
To t To t	2	29b. Signature and title of	certifier	Mi	tit	1.5	)		3365		$\frac{9}{9}$	d (Month,	Day, Year)
8		30. Name and address of p	erson who	completed car	e 4	05	Fre	rint)	Q,# 20.	2, Bak	timor	e, M	D 21228
Stat Registra		31. Date filed (Month, Pay,	1 2 2	007 32.	egistrar's S	Signatu	A	selv					

DHMH 17 Rev 1/2001

Registrar

Billes

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate o			giene 0 0 7	22357
	0.		1. Decedent's Name (First, Middle, La	ist)				2. Date of De	ath	3. Time of Death
	Physic /Medi		Helen Mari	e Free	eman			July	7, 2007 Year	1:21 P M
	Exami		4a. Facility Name (If not institution, given			4b. City, Town	, or Location of	f Death	4c. County of Dear	
			1204 Lake Falls	Road		Balti	more		Baltimo	re
	Funeral Director	01C 20 2400 1 M 2ME 07				If Under 1 Yea Months Day	ar If Under 2	Min. 8. Date of Bir (Month, Da Sept. 2	9. Bird	hplace (State or Foreign buntry) MD
	p.		Usual Residence of Decedent			1		1		,,,,
	arylar show	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	8a-f	cto	MD Baltim	ore	В	altimore			-	1 ☐ Yes 2 No
	with th	Dir	10e. Street and Number	D d		10f. Zip Code			10g. Citizen of What Co	ountry?
	s 23	ra	1204 Lake Falls		E : 110	21210			USA	
36	ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or flems 23a or 28a-f show or other traumatic event, the Medical Examinator traumatic event, the Medical Examinator traumatic event.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Tyes 2 X If Yes, Give	No	Was Decedent o If Yes, specify Cu 1 ☐ Yes 2 ☑ N	uban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
21215-0036	hour turaf	d b	3 X Widowed 4 ☐ Divorced	Year or Dates:	1 10 0		e -ita i			
5	n 72 "nat	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occ kind of work don DO NOT use reti	supation ne during most	of working	16b. Kind of Business	Industry
12	withii iene. than	gm.	Elementary/Secondary (0-12)	College (1-4or	5+)	emaker	( <del>0</del> 0)		Own Home	
	filled Hygie othar ant, II		17. Father's Name (First, Middle, Last	)	110111	Cinakei	18. Mother	's Name (First, Middle,		
Maryland	should be ind Mental Is marked o	To Be	William	Joseph	Smit	h	El		Smit	h
lar	2 sho and Is me	10	19a. Informant's Name/Relationship (	• • • • • • • • • • • • • • • • • • • •					er, City or Town, State, 2	Zip Code)
	s 1 and 27 Health Item 27 othar tr	- 1	Bette E. Stewart/	Granddaugh	iter 1204	Lake Fa	alls Rd			
0	ges it of h		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		natory or other p		Date	20c. Location - City or	
Baltimore,	t. Pa tmen tant: ijury		* 4 □ Donation 5 □ Other (Special		New Cath			/12/07	Baltimore	
Bal	permit. Pages Department of Important: If II any injury or once.		21. Signature of Funeral Service Lice	Pudu				Ruck Towso Towson, Mi	on Funeral 21204	Home, Inc.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not ent					Approximate Interval Between
	Physician	0.1	Immediate Cause (Final disease or condition	Α .	iosderot	_ Card	Louise	clar DIA	eose	Onset and Death
	/Medical		resulting in death)	a	a consequence of):					gas
	Examiner		Sequentially list conditions,	b.						· ·
	p is	Examiner	cause. Enter Underlying Cause (Disease or injury	Clie to (or as	a nonsaquence of):					
V	ecute and -trans	каш	that initiated events resulting in death) Last	C. Due to for an						
8760,	death certificate be executed e attending physician and d for use as the burial-transit	E E		Due to (or as	a consequence of):					
87	physic the last	dical		d						
9 x	ath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				nad Data of dal	
Вох	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnan Other (specify)	псу		23d. Date of del Month	very Day Year
o.	at the de by the tached	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown	5	t Guier (apochy)				
σ.	that	by Pt	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause g	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	The law requires that the te has been signed by the bage 2 shruld be detached.	ed b						101	∕es 2□No 3□Pr	obably 4 Unknown
900	e law requ has been je 2 sh. uk	Completed						24a. Was		topsy findings available
Ř	The late had page	ШО						autop perfo	rmed? death?	completion of cause of 2□ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place	of Death (Check only o		
of V	2 = 5	To	1 Yes No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	t 3 DOA	ther: 4 🗆 Nurs	sing Home	dence 6 □Other (Spec	cify)
			27. Manner of Leath  Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time of Injury	28c. inj W	ury at ork?	28d. Describe h	now injury occurred	
Sio	Attanding r death. actor: After you the fune	catl	a Accident investigation	1			⊒Yes 2□N	0		
Division	o in Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc	ury - At home, farm, str c. (Specify)	eet, factory, office	9	28f. Location (S City or Tox	Street and Number or Ru n, State)	ral Route Number,
	Hospital		29a. Certifying Ph	veicien: To the heet	of my knowledge, death	cooursed at the	time data and	place and due to the	cause(s) and manner as	
	24 h	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	f examination and/or inv	estigation, in my	opinion, death	occurred at the time,	date and place, and due	to the cause(s)
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Me	29b. Signature and title of certifier			29c Licer	nse number		29d. Date signed (Monti	n, Day, Year)
	0		Dendal	Rough	llen	7	256	4-3	07/10/2	<del>)0</del> 07
	6		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, 16565 N . (	Print)	S+5,,	it was	Broots	W 21201
• .	Sta		31. Date filed (Mooth, Day, Year)  1 2 2007	2. Registra	ar's Signature	به سرادی .	31 -100	uc a 1/	auc 16.	= 41404
	Registr	ar	00 T T 7 7001	Down	& Span					

7/7/07 1:18PM

Freeman, Helen

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Thomas Francis, Jr.	State of Maryland / Department of H 1-For State Certificate of D	oath	2007 2.235 g. No.							
Physician/ Medical Examiner	Registrar  1. Decedent's Name (First, Middle,Last)  Thomas S. Francis	2. Date of Death Month July 9, 200	Day Year 1143 hrs							
The state of the s	4a. I don'ty Hame (if not included), give all all all all all all all all all al	City, Town, or Location of Death Silver Spring	4c. County of Death  Montgomery							
Funeral Director	5. Social Security Number	if Under 1 Year If Under 24Hrs. 8. Date of Birth Months Days Hours Min. April 8	n (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) PA							
d de any	Usual Residence of Decedent  10a. State MD Montgomery 10c. City, Town or Location Si	lver Spring	10d. Inside City Limits 1 X Yes 2 No							
th the Maryland  23a or 28a-f show  notified at once.	10e. Street and Number 1001 Spring Street, Apt. 522	0f. Zip Code	0g. Citizen of What Country? USA							
2 hours after death w "natural", or items Examiner must be	Armed Forces?  Armed Forces?  Yes 2X No  Widowed 4 Divorced Fyes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Decedent of Hispanic Origin? (Specify Yes or No- specify Cuban, Mexican, Puerto Rican, etc.)  Bes 2 X No specify:  Usual Occupation (Give kind of work done of working life. DO NOT use retired)	14. Race - American Indian, Black, White, etc. White Specify:  16b. Kind of Business/Industry Furniture							
5-0036 Iled within 72 Hygiene. Jother than 'the Medical	12 17. Father's Name (First, Middle, Last) Thomas Francis	18 Mother's Name (First, Middle, Marian Maria								
Baltimore, MD 21215-00; bennit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other traumatic event, the Mediuty or other traumatic event, the Mediumy or other traumatic event, the Mediumy or other traumatic event, the Mediumy or other traumatic event, the Mediumy or other traumatic event, the Mediumy or other traumatic event, the Mediumy or other traumatic event, the Medium of the M	19a Informant's Name/Relationship (Type, Print ) 19b. Mailing A	ddress (Street and Number or Rural Route Num East Grandview Apt.323)	nber, City or Town, State, Zip Code)							
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 njury or other traum	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition crematory or other BayView Cr	on (Name of cemetery, Date July 11,200	20c. Location - City or Town, State 7 Baltimore, MD							
Baltimo permit. Pag Department Important: injury or ot	1 5 Jan 1 0 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ne and Address of Facility Arles L. Stevens Funera Dl East Fort Avenue, Ba	altimore, MD 21230							
Physician Medical aminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atheroscleratic conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):									
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):									
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transition of the physician for the p	J. AMENDED X AMENDED X AMENDED 23a, 27, perME, 8871, 9/7/07 TT  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?									
P.O. Bas that the degree by the detached by the detached by the detached by the detached by the base by the detached by Device by Device by Device by Device by Device by Device by Device by the detached by Device by		derlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?  es 2 No 3 Probably 4 ✓ Unknown							
of Vital Records, P.O.  ng Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detach.										
an: II Re ertifica ctor, pa	25. Was case referred to medical	26.Place of Death (Check only one)								
Division of Vital I Hospital or Attending Physician: 24 hours after death. tely filled in by the funeral director.	1 Yes 2 No 1 Inpatient 2 Ervoupatient	3 BOA 4 Huising Home 0	Residence 6 🗸 Other: Scene how injury occurred							
Division or Spiral or Attending hours after death.  Figure 1 birector: After willed in by the fune	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State)							
To the Hospital within 24 hours To the Funeral completely filled		ed at the time, date and place, and due to the cau	use(s) and manner as stated. e and place, and due to the cause(s)							
To the Ho within Fu to the Ru to the Euclideal	29b. Signature and title of certifier  Donna WWincont M.D.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) July 10, 2007							
27	30. Name and address of person who completed cause of death (Item 23a)	Penn Street, Baltimore, MD 21201								
Sta Registr	e 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ods								
DHMH 17 Rev 1/200	OPIONIAL	(2), <del>1-2</del> (1								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav 0:03 P 10 Veronica Agnes France 2001 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimor Franklin Square Hospital Kosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan . 28 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 34 □ F Min. 217-05-2415 89 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 324 Poplar Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 3 ☐ No Specify. Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary John Hopkins 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Jachelski Helen Zielinska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas France /son 337 Upperlanding Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 7/11/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 300 Mace Ave.Balto. MD all Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the Gath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Spiration disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? /es 2⊠No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician for use as the huria ed by the a detached for signed by t d be detach this within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral

Physician

/Medical

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification:

Medical

29a. Certifier

29b, Signature and title of certifier

Wass.

31. Date filed (Month, Day, Year)

Examiner

**Funeral** 

Director

ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea one.

Physician

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Hitti 9000 Franklin Square Drive Baltimore MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

EcrtifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** Stephen Thomas Flottemesch 145 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner KIVERSIDE WRIED it Onder 24 Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Міп 88 Yrs. 215-36-8083 Director May 27, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 ie marked other than "naturei", or items 23s or 28s-f ehow treumstic event, the Modical Examinar must be notified at 1 Yes 2 No Directo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 USA by Funeral 733 Magnolia Road permit. Pages 1 and 2 should be filed within 72 hours after deal Dependent of Health and Mental Hygiene. Important: If tam 27 ie marked other the eny injury or other treamment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ဂ Henry Jospeh Flottemesch Mary Elizabeth Dwaayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Philidelphia Road, Abingdon MD Paul J. Flottemesch/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Crem 3 Rem al from State St. Stephen's Cath. 07-12-07 Bradshaw, Maryland 5 🗆 Ot (Speoty) 21. Signati 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 400 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has tirector, page 2 s autopsy performed? 2 No 1 Yes 2 N or Attending Physician: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 ELN6 1 Inpatient 2 ER/Outpatient 3 DOA 42 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 12 Natural 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, within 24 hours e completely

Stephen

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. R strar's Signature

State

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State of	Maryla	nd / D	epartment	of Heal	th and	Mental	Hygiene	01

Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 5:33 AM GKA 200 ES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTI SECOURS 04 MOR tospil AL If Under 24 Hrs. Birthplace (State or Foreign
 Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 276 1**X**M 2□ F **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 No 2 No Director 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Deceded a 2 No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u>a</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WORKER 12 TH GRADE 17. Father's Name (Firşt, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SISTER URTON LICE GRAV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 □ Cremation D- 6 20c. Location - C 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee EPN int1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or in art failure. List only one cause on each line. Im y diate C yr e (Final di rase or c r dition r ulting in death) NGEAL **Physician** /Medical Due to (or as a consequence of): Examiner LI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 donknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 29a) Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 JUL 2007

Registrar DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** July 7, 2007 6:05  $A^{M}$ Grimm Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year)
Sept. 23, 1921 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🛣 F Director 093-12-5957 85 New York Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Baltimore White Marsh 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4413 Hallfield Manor Drive 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White 2 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Legal Secretary Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace Simmons Bertha Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traum once. Barbara Jacobs (Daughter) 1921 Sue Creek Dr., Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 7/10/07 4 □ Donation 5 Other (Specify) Alexandria, VA 22. Name and Address of Facility
Capitol Funeral Service 21. Signature of Funeral Service Licens 7211 Lee Highway, Falls Church, VA 22046 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Amyloid asis EeK5 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the last of the last o Due to (or as a consequence of): Examiner signed by the attending physician and abe detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other:  $4 \square \text{ Nursing Home} \quad 5 \square \text{ Residence} \quad 6 \cancel{R} \text{Other } (\textit{Specify}) \text{Hospice}$ 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JULY 7, 2007 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) コロティーバル (イル)

Registrar

State

Touson MA 21204

209

ST. Suite

32 Registrar's Signature

North Charles

31. Date filed (Month, Day, Year)

JUL

			1 - State Registrar				Cer	rtificate	e of L	Death			Reg. N	10. UI	11	420	, O
-	Dhomisi		1. Decedent's Name (First, Middl	le, Last)								2. Date of Do		Day	Year	3. Time of	Death
	Physici /Medic		Robert Arthur	Gilbert								July 9			i eai	10:14	P. M
	Examin		4a. Facility Name (If not institution	n, give street and r	umber)			4b. City,	Town, or	Location	of Death		4	c. County	of Death		
			4508 Prestwood	Drive				01ne					1	lontgo	mer	у	
	Funeral Director		5. Social Security Number 271–30–4327	6. Sex 1 <b>⊠</b> M 2□ F		In yrs. las 34	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Di May 8,	av, Yea	23	9. Birth <i>Cou</i> [111	place <i>(State</i> o ntry) <b>nois</b>	r Foreig
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	8a-f	Director	Maryland Montgo	omery		lney											212140
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	ath v s 23a nust	Funeral	4508 Prestwood					208						ted S			
	er de	nue	11. Marital Status	12. Was De Armed	Forces?	er in U.S.	13. \	Nas Deced f Yes, spec	lent of Hi lify Cuba	ispanic Ori ın, Mexica	rigin? (Spe ın, Puerto	cify Yes or N Rican, etc.)	0-		· - Ameri ‹, White,	can Indian, etc.	
2	s aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes (	2 ☑ No			1 ☐ Yes 2	2√ No	Specify:	:			Specify:	T.Th d	+0	
3	hour tural al Ex			nt's Education	Dates.		16a Deced	dent's Usua	I Occup	ation			16h	Kind of Bus			
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7	with iene. than	Completed	Elementary/Secondary (0-12)	College 5	(1-4or 5+) +			ct Ma					Fe	dera1	Gov	ernmen	t
2	I Hyg other ent,	Be C	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	(First, Middle	e, Maide	en Surname	e)		
2	lenta Tenta Ked	To B	Daniel Chester	Gilbert						E11a	Athr	on					
<u> </u>	shot and N s mai		19a. Informant's Name/Relations				19b. Mailin	g Address	(Street a	and Numb	er or Rura	l Route Numb	per, City	or Town,	State, Zij	o Code)	
Ž	alth alth 27 is		Rebecca L. Grov	res / Dau	ghter	4	4216	F1owe	r Va	11ey	Dr.	Rocky	'i11	e, Ma	ry1a	ind 208	53
נ	of He item		20a. Method of Disposition			20b. Plac	ce of Dispo	sition (Nam	ne of ther plac	e) !	С	ate	20c.	Location - 6	City or T	own, State	
=	Page nent nt: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other					orial E		· i	July 1	2, 2007	011	iey, N	lary.	land	
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any finury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Se vice	Licensee								al Home/					
٥	o an De		xc.1-	10	M	0089	$6 \begin{vmatrix} 30 \end{vmatrix}$	O W.	Mont	gome:	ry Av	re., Ro	ckv	ille,	MD	20850-	280
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that	caused th	e death.	Do not ente	er the mode	e of dyin	g, such as	s cardiac o	r respiratory	arrest,			Approximate Interval Bety	e ween
	Physician		Immediate Cause (Final disease or condition	1	UTD		Ken								6	Onset and D	Death
	/Medical		resulting in death)	a. Due t	o (or as a c		*									1	-
	Examiner		Sequentially list conditions	b	ymp	hou	N									Chon	10
	р <del>і</del>	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due t	o (or as a c	onsequer	nce of):										
	ecute and trans	am	Cause (Disease or Injury that initiated events resulting in death) Last	c	,												
5	e exe sian a urial-		resulting in death) Last	Due to	o (or as a c	onsequer	nce of):										
	leath certificate be executed attending physician and for use as the burial-transit	Medical		d					-								
<b>&gt;</b>	ing page as		IF FEMALE:	20- 14													
2	ath c	Physician/	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal de	eath 3	Ectopic pre						23d. Date Mor			/ear
5	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pre 9□Unk	gnant at tin nown	ne of deat	th 5∟	Other (spe	ecify)							,	
-	w requires that the death cer been signed by the attendin should be detached for use		Part II. Other significant condition	ons contributing to	death but r	not resultin	ng in the ur	nderlying ca	ause dive	en in Part I	I.	23e. Did	tobacco	use contri	ibute to t	he cause of d	eath?
ה ב	signe d be	by		3			3	, ,				1				bably 4 □U	
5	requ been should	Completed			_												
2	has las	du										24a. Was		24b. V	vere auto	opsy findings a ompletion of ca	available ause of
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2	siciar certif recto	Be	25. Was case referred to medica examiner?	Hospital:					Othe	ar.		(Check only	one)				
5	Phy r this ral di	. To	1 Yes 2 No  27. Manner of Death	, 1 <sub>L</sub>	Inpatient e of Injury		NOutpatien  Bb. Time of	t 3 DO	^	4 ∐ NI	ursing Hor	ne 5 Res 28d. Describe		6 □Othe		fy)	
5	ding h. Afte fune	Ej.	1  Natural 5  Pendin 2  Accident investi	ng (Mo	nth, Day Y	'ear)	Injury	м	8c. Injury Work	Yes 2□		Loui Describe	11044 111	july occurre	Ju		
2	Atten deatl ctor: y the	fical	3 ☐ Suicide 6 ☐ Could	not be	e of injury	- At home	e, farm, stre	eet, factory		.00 2		28f. Location	Street	and Numbe	er or Rur	al Route Numi	ber.
	after after Dire d in b	Certification:	4 ☐ Homicide determ	buil buil	ding, etc. (	(Specify)						City or To					,
	hours nera y fille		29a. Certifier 4 Certifyir	ng Physician: To t	ne best of r	ny knowle	edge, death	occurred a	at the tin	ne, date ar	nd place,	and due to the	cause	(s) and mai	nner as :	stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical one)	Examiner: On the and ma	basis of ex nner state	camination d.	n and/or in	vestigation,	in my o	pinion, dea	ath occurr	ed at the time	, date a	and place, a	and due	to the cause(s	)
	To t To t	N	29b. Signature and title of certifie	t,				29c.	. License	number			29d. [	Date signed	(Month,	Day, Year)	
			Mun	m	.()			2	:31	77	_	-	7	11 11	, 21	207	
Î	5		30. Name and address of person	who completed ca	use of deat	h (Item 23			Λ :		, il	202	0	. 11		100	7
I	9		John Wallmar	K, MD	4.	101	Med	1Cal	Cent	er &	DV. #	300	KOC	KVIII	CIN	10 20	とな

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 30/0 M **Physician** JUNE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEALTHA entek Nenleaf 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Min. Months Days Hours 1 □ M 2 F 219-10-6682 Director N.C Usual Residence of Decedent the Maryland 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10b. County Yes 2 No Director BAITIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a ~~ one. 21.5.A 2/23 by Funeral 16/6Win 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: BIACK 3. Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home MAKER 8th GRAde NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1:11.e BAITIMORE 21239 MD 20a. Method of Disposition 20b. Place of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 ☐ Other (Specify) cen 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2, m1 2/2/3 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** type tenous /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter U.J. Jan, u.g. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Bleed The law requires that the death certificate be executed gartra meter physician and s the burial-trans Due to or as a consequence of): Physician/Medical attending p IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 No Be

Division or Vital Records, P.O. Box 68760, certificate has t irector, page 2 s To the Hospital or Attending Physician: director, this funeral After within 24 hours after death.

To the Funeral Director: Af

25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 ☐ Yes 2<u>₽</u> No 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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821 N. ENTAW ST Snite 30f, BALTIMORE MD 21201

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DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day, Year)

Medical Certification: To

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASHMI

MD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc e869 7-12-07 with and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 1, 2007 12:50 am Violet May Haller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie 7927 Roxbury Drive Anne Arundel 8. Date of Birth (Month, Day, ) April 2, Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 7 F 91 216-18-7330 1916 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 XYes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1112 Scott Street 21230 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: white 3 N Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bottling Department Distillary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eva Tanner George Ensley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Welham Avenue Glen Burnie Geraldine Fisher/Daughter MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

Donation 5 ☐ Other (Specify) 07-07-2007 Brooklyn, Maryland 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that cau the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home \*\*\* Nursing Home \* Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death residence 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day,

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30]

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

filled in by the funeral within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral

Be

Certification; To

Medical

State

Division or Vital Records, P.O. Box 68760

autopsy performe 1∐ Yes 2X No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No

25. Was case referred to medical examiner?

5 ☐ Pending investigation 6 ☐ Could not be determined

1 npatient 28a. Date of Injury (Month, Day Year)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Yes 2 ☐ No

27 Manner of Death

2 T Accident

3 ☐ Suicide

4 ☐ Homicide

12 Natural

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 67-09-200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

living Star NOH 101, FOT WAICELE MD 20749 Michael Sidanous, on-p 11701

31. Date filed (Month, Day, Year)

32. Régistrar's Signature

/illiam Roland	Hos	to State of Maryland / Department of Health and Ment			
		1- For State Certificate of Death Registrar	Reg	200	1 2000
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last)  William Roland Hosto	2. Date of Death	Dav Year	3. Time of Death 1757 hrs
		4a. Facility Name (if not institution, give street and number)  38 Glenwood Ave  4b. City, Town, or Location or Catonsville		4c. County of Death	
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birl	
Director		345-44-1290 1X M 2F 57 Yrs. Months Days Hours Usual Residence of Decedent	May 26,	Foreig	
any		10a. State 10b. County 10c. City, Town or Location	-		10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	to	Maryland Baltimore Catonsville			1 Yes 2 X No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 10f. Zip Code 21228	. 10g	. Citizen of What Cour USA	itry?
with t	ra	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig	in? ( Specify Yes or No-	14. Race - Ameri	can Indian, Black,
death or iter	ij	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	White, etc.	
s after ral",	by	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	-	Specify: Whi	
2 hour	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give k during most of working life. DO NOT in the control of the co		6b. Kind of Business/I	ndustry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I filem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	Completed	5+ Teacher	Alam (Cina Middle Ma	Colleg	;e
Baltimore, MD 21215-00: pernit Pages I and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other thinjury or other traumatic event, the Med	Be C		s Name (First, Middle, Ma Ruth Meyer	iden Sumame)	
21 hould nd Me is ma	5	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Num			, Zip Code)
MD and 2 sho salth and em 27 is		Lisa C.M. Lelli, Sister 3039 South Longmon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	ce Mesa, AZ	85202 20c. Location - City or	Taura Chata
Baltimore, permit Pages I ar Department of Her Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)		•	
Itim it Pag ritment ortant		4 Donation 5 Other Specify: Metro Crematory Inc.  21. Signature of Funeral Service Licensee 22. Name and Address of Eaclity.	07/12/07	Baltimore	, Maryland
Balt permit Depart Import injury	J	21. Signature of Funeral Service Licensee  Thomas Gregor  Thomas G	lety Of Mary	land, Inc.	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. List only one cause on each line.	ardiac or respiratory arres	t, shock, or heart	Approximate Interval
/Medical		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.			
nted d ansit		events resulting in death) Last  Due to (or as a consequence of):			
ox 68760, sath certificate be executed attending physician and ior use as the burial - transi	sician/Medical	UNPENDED AMENDED			
Box 68760 e death certificate b the attending physical for use as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d. Date of delivery	pay Year
lox 6 eath cer eattendi	sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  9 Unknown			
b.O. Be that the de ned by the detached f	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt I. 23e. Did toba	acco use contribute to	the cause of death?
P.O. ires that the signed by libe detac	d by		1Yes	2 No 3 Prot	ably 4 🗸 Unknown
cords faw requi	ompleted		24a. Was an autopsy	prior to o	topsy findings available ompletion of cause of
Rec The la cate hu	E O		perform 1 <b>Y</b> Yes 2		s 2 No
tal Rectinn: The certificate ector, page	BeC	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4			
of Ving Physical After this	P	TYPES 2 NO		esidence 6  Other winjury occurred	: Scene
ion of tending Pheath.	ation:	27. Manner of Death  1 V Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2		w mjary obsamos	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be deached for use as the buri	Certification:	3 Suicide 6 Could not be determined (Specific)	28f. Location (Str or Town, Sta		ral Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only one)  29b. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate one)			
To the within 2 To the complet	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (Moi	
	-	O.C.M.E.	1	July 10, 2007	, Day, 1001/
15	Ì	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01		
r		2. S. S. S. S. S. S. S. S. S. S. S. S. S.			

Registrar

OCME

07-05183 Anissa Hoilett

Physician/

Mediçal Examiner

**Funeral** 

Director

s 23a or 28a-f show e notified at once. or 28a-f show

or items

"natural".

Department of Health and Montal Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical

Director

Funeral

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Compl

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, MD 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day July 6, 2007 1440 hrs Renee Hoilett Anissa 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number July 4,1980 County Jamaica Months Days Hours 225-51-4477 27 Female Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ob. County Va. James City Williamsburg Yes 2 X XNo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1647 Skiffs Creek Circle 23185 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Yes Specify: Black If Yes. Give Year Yes 2 X No specify: Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Licensed Practical Nurse Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Hoilett Olive J. Walker Errol Ρ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 23 1 8 5 19a. Informant's Name/Relationship (Type, Print) 221 Tarleton Bivouac Williamsburg, Vã. Errol P.Hoilett-Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Williamsburg, WMSBURG Memorial **p**k. 7-16-Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Whiting Funeral Home Trail Williamsburg Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Death failure. List only one cause on each line.

**Physician** /Medical aminer

and transit i signed by the a d be detached fo has been si r this certificate hal director, page Funeral Director: stely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

24 hours after death.

To the

_ [	Immediate Cause (Final disease	<sub>a.</sub> Multiple Injuries					
	or condition resulting in death)	Due to (or as a consequence of	f):				
Physician/Medical Examiner	events resulting in death) Last	b			7 3 1	• .	
dica	UNPENDED	AMENDED					
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ✔ Unknow	23c. If yes, outcome of preg  1 Live birth 4 Pregnant at time of de	2 Fetal death		ancy	23d. Date of deliven Month	y Day Year
	Part II. Other significant condition	s contributing to death but not n	esulting in the underlying	g cause given in Part I.	1 Yes		pably 4 🗸 Unknown
Completed by					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of es 2 No
0	25. Was case referred to medical			26.Place of Death (Check	only one)		
o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	OOA Other Nursi	ng Home 5 Re	esidence 6 Othe	r:
ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investig.		28b. Time of Injury 1402 hrs	28c. Injury at Work?  1 Yes 2 ✔ No	28d. Describe how Passenger of		vehicle accident
Sertification:	3 Suicide 6 Could n  4 Homicide	ot be 28e. Place of Injury - At h	ome, farm, street, factor	y, office building, etc.	or Town, Stat		ural Route Number, City r Spring, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

31. Date filed (Month, Day Y

eted cause of death (Item 23a)

29c. License number O.C.M.E.

29d. Date signed (Month. Day, Year) OCME July 7, 2007

30. Name and address of person who Theodore M. King, Jr., MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

Medica

ORIGINAL

			State of Maryland a,29d per Hypry,	Certific	ent of H 2/0/dhb ate of L	ealth and Death			2007	2225
Physici		1. Decedent's Name (First, Middle, Last)  PAULA  BOR	MEL		HO	OPER	2. Date of De Month	eath Day <b>6</b>	2007 Year	3. Time of Death 7:00 A
/Medio		4a. Facility Name (If not institution, give st		4b. 0		Location of Dea			County of Death	
	X) .	10598 TOPSFIELD DE			CKEYSV				BALTIMO	RE
Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (In yrs. last	Yrs. If Ur	nder 1 Year ths Days	Hours Mir		ay, Year)	9. Birth	pplace (State or Fore intry)  MD
M 1		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location						10d. Inside City Lim
Fied a	tor	MD BALTIN	MORE CO	OCKEYSVI	LLE					1 □ Yes 2 □
or 28a	Director	10e. Street and Number			. Zip Code			10g. Citi:	zen of What Cou	intry?
s 23a nust b		10598 TOPSFIELD DRI			210				U.S.A.	
ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1		ecedent of His specify Cubai es 2 X No	spanic Origin? ( n, Mexican, Pue Specify:	Specity Yes or No rto Rican, etc.)	0-	14. Race - Ameri Black, White Specify:	
natura dical E	Completed	15. Decedent's Educa (Specify only highest grade	ation 1	6a. Decedent's t	f work done d	uring most of w	orkina	16b. Kii	nd of Business/In	ndustry
than "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NO	T use retired)	3	· · · · · · · · · · · · · · · · · · ·		DETAX	
al Hygie other 1	Be Co	17. Father's Name (First, Middle, Last)	2		SALES	18. Mother's Na	ame (First, Middle	, Maiden	RETAII Surname)	
and Mental is marked o	To B	DAVID		NASDOR		FAYE			BLIN	NDER
and is m		19a. Informant's Name/Relationship (Type		•	•		Rural Route Numb			,
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는 끝 듣		21. Signature of Funeral Service Licensee	, (AIT	Z CHAIM 22. Nam	) CONG e and Addres		L LEVINS		•	
Depar Impor any ir		Matt Leur		8900	REISTE	RSTOWN	ROAD - P	UN & IKES\	/ILLE. M	INC. ID 21208
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. [							Approximate Interval Between Onset and Death
physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate the list in the list of the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	,						
e attending d for use as	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2\( \text{MLNo} \)	c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	ath 3□Ectop	ic pregnancy r (specify)			2	23d. Date of deliv	very Day Year
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ate has been signed by thosage 2 should be detache	5	Part II. Other significant conditions cont	nbuting to death but not resultin	ig in the underlyin	ng cause give	n in Fan i.				the cause of death bably 4 ⊟Unkn
been si	Completed			-			24a. Was			opsy findings avail
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certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	1  Yes eath (Check only		I I I Tes	2L NO
this ce	မ	1 ☐ Yes 21 No			DOA Othe	4 Livuising	Home 5 Res			ify)_
ifter death.  • Irector: A ser this certifican by the fureral director,	ion:	27. Manner of Death  1 ANatural 5 □ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury M	28c. Injury Work	at ? 'es 2 □ No	28d. Describe	how injury	y occurred	
	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At home building, etc. (Specify)			65 2 1140	28f. Location ( City or To			ral Route Number,
vithin 24 hours a  To the Funeral  completely filled	edical		cian: To the best of my knowle er: On the basis of examination and manner stated.							
To t	ž	29b. Signature and title of cartifier			29c. License	number			e signed (Month	, Day, Year)
		17)my			200	218326	> 4	шу 6	, 2007	
2/		30. Name and address of person who com	npleted cause of death (Item 23	(Type, Print)	00	1	travil	, -	Α 24.	× ~ ~
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25, 25, 27 per Ary 1909, 67 poor tracent of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2007 4:49 AM M Jesse Harris June 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 1952 54 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 22s constant by Injury or other traumette. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No CA Director Los Angeles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1419 N. La Brea Street 90028 USA Funeral unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify: black ģ 3 ☐ Widowed 4 ☐ Divorced unk Completed UIT16 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suburban Hospital 8600 Old Georgetown Road Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Nother (Specify) in state 21. Signature of Euneral Service I 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street wade, Director Raltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate dause (Final disease or condition resulting in death) Prevmonia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine law requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g 1 Tes 2 No 3 Probably 4 Unknown molnytrition Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Threm be cytopenia 24a. Was an hyperkalemia autopsy performe Pericardial 25. Was case referred to redical examiner? 1□ Yes 2☑No To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1

Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JUL 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hossein Akhondi Asi, 8600 Old Georgetown Road, Bethesda, MD

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

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Records,

Division or Vital

HARRIS

29c. License number

D0062167

29d. Date signed (Month, Day, Year)

6/18/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year :00 AM 2001 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 000 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Months Hours Year) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces? 1 Des 2 □ No If Yes, Give Year or Dates: (UUII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BIACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) en Boston MeTAle. GRAd Monz 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) -1560A Ackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 202 BATTO. ND ACKSON 1401 LAKe wood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Wings Mills MI 22. Name and Address of Facility
Betts French Home
1129 N.C. Hadine St. BATE IND 181213 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Due to (or as a consequence of): Sequentially list conditions, if any cause the Underlying Cause (Disease or injury Due to (or as a nonsequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan төа? 2**) (** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: ursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident investigation 1 🗌 Yes 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined

Examiner The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, attending physician for as been signed by the a this certificate has page ; Hospital or Attending Physicien: funeral director, After Director: / filled in by within 24 hours at

**Physician** 

**Funeral** 

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**Physician** 

/Medical

Director

Funeral

Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

other traumatic event, the Medical Examiner must be notified at

72 hours after

Pages 1 and 2 should be filed within

Health and Mental

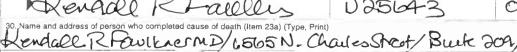
altimore, Maryland 21215-0036

/Medical Examiner

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



29c. License number

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Balto MD 21204

mgistrar's Signature 32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM/7, 18, per HT. 12, 23e, per HT. 15, 0009, 7/2/107, WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** Jackakay P. Johnson July-17:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Cheverly Prince George Hospital 8. Date of Birth (Month, Day, Oct 26, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2√2F **80** Yrs. Florida 131 22 1233 1926 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □ Yes 2 □ No Director Upper Marlboro Maryland | Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9917 Stonewood Court, 20772 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes **②** No If Yes, Give Year or Dates: 1 Never Married Married African Specify: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Gamming 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pansy Jean Glovers Jacques Pincheon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9917 Stonewood Court, Upper Marlboro, MD 20772 Rory- Duke Johnson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) July 13, Pat 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cheltenham, Maryland 5 Other (Specify) Maryland Veterans Cemetery 21. Signature of Funeral S. vice Ly a se 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD m00257 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chromic obstructive Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): congestine Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Dement Physician/Medical attending properties as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 KNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ + Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? this certificate 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar

DHMH 17 Rev 1/2001

5001

Dr. Cheverly UD20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MUKEMII Abdella, MD

31. Date filed (Month, Day, Year)

1 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 10g, 12 per fh 88/0 8-14-0/vt.
State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 9 2007 JUL 3:02 A GEORGE WESLEY JOHNSON 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Days Hours Min. Months XX M 2 ... F 440 14 1893 Dec 16, 86 1920 0klahoma Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United 7901 Jean Court 20735 States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ev¶r946 Armed Forces? 1 Yes 2 No 1956 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No If Yes, Give Specify. 1962 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retired Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Walter Johnson Edna J. Stroud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Johnson 7901 Jean Court, Clinton, MD (Wife) 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 2, 2007 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Arlington, VA 4 Donation 5 Other (Specify) Arlington National Cemetery 22 Name and Address of FacilityLee Funeral Home, Inc 6633 Old of Funeral 160 700153 Alexandria Ferry Road, Clinton, MD al 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

be executed P.O. Box 68760. death certificate Division of Vital Records,

**Physician** 

/Medical

**Examiner** 

10a State

**Funeral** 

Director

ral', or items 23a or 28a-f show Examiner must be notified at

"natural" er than "nature.

other

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permit. Page Depertment of Importent: If any Injury or once.

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Certification:

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29b. Signature and title of certifie

29a. Certifier

with the Maryland

death

filed within 72 hours after

1 and 2 should be Health and Mental is marked

Pages nent of h

Maryland 21215-0036

Baltimore,

signed b should b been cate has l this certificate director After thi or Attending To the Flores after death.
To the Funeral Director: After the funeral Director of the funeral Director of the funeral by the f To the Hospital

> 3 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES R. HOLLIS MC USN 31. Date filed (Month, Day, Year) 200

2

32. Registrar's Signature

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2N Medical Examiner: On the basis of examination and/or investigation in the property of the pr

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0101240449 (VA)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

10

2007 07

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Phyllis Charlene		nson 1- For State Registrar	Š	tate of Maryla	and / E	epartment o Certificate o		d Mental H		g. No.	] [	7 3 7
Physicia Medical Examir	n/ ner	Decedent's Nam     Ph	nyllis	Shar	cline		Johnso	on	2. Date of Death	Dav Yea		3. Time of Death 2305 hrs
(		4a. Facility Name ( Johns Hopk		on, give street and no	umber)		4b. City, Town, or Baltimore	Location of Dea	th	4c. County o		
Funeral		5. Social Security I		6. Sex	7. Age (li	n yrs. last birthday)	If Under 1 Yea	ar If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY	9. Birth	
Director		218-86-68	392	1 M _ 2X F	200	40 Yr	Months Day	s Hours Mi	n. 2–28-	-1967	Foreign Cour	ntry) N.C.
me		Usual Residence o	f Decedent	,	110	c. City, Town or Loca	tion					10d. Inside City Limits
<b>*</b>	_	Md.	NA			Baltimo					l l	1 X Yes 2 No
4arylar 28a-f s Laton	Director	10e. Street and Nu	ımber	9.		-	10f. Zip Code		10	g. Citizen of Wh	at Count	ry?
ith the Maryland 23a or 28a-f show notified at once.		1710 N	. Broa	dway			212	213		USA	7	
ath wit items 2 st be r	Funeral	<ol> <li>Marital Status</li> <li>Never Marri</li> </ol>	ied 2 N	12. Was De Armed F	orces?	lf `	as Decedent of His Yes, specify Cubar			14. Race White		an Indian, Black,
fter de: [", or i		3 XWidowed		1 Yes	ar <sup>2</sup> X	No 1	Yes 2 No	specify:		Specify:	Bla	ack
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5-0036 led within 7 Hygiene. other than	틠	17. Father's Name		e, Last)					ne (First, Middle, M	aiden Surname)		-
2121! vuld be fil Mental H. marked ic event, t	å	Leo				Neville		Mag			effer	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	P	19a. Informant's Na Ceasar I	Nevill			17	10 N. Bro	oadway,	Rural Route Numl Baltimor	e, Md. 	21:	213
or Head of Head of Head If iter		20a. Method of Dis 1 Surial 2		on 3 Removal f	rom State	20b. Place of Dispo crematory or o		metery,	Date	20c. Location -	City or T	own, State
Baltimore, cernit. Pages I an Ocpariment of Hee Important: If ite Important: If ite Injury or other tr		- 23	Other S	Specify:		Woodlaw	n Cem. Name and Address		11-07	Baltin	nore.	,_Md.
Bal permi Depar Impo		21. Signature of Ft	MARILLA MARILLA						March F.		Mđ.	21202
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	Examiner	(Disease or injury	ellying Cause	с								
		events resulting in		Due to (or as a	a consequ	ence of):						
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6876( certificate nding physes as the b	žΙ	IF FEMALE: 23b. Was decedent		23c. If yes,	outcome o	of pregnancy	etal death 3	Ectopic pregr	nancv	23d. Date of Month	delivery Da	ay <b>Ye</b> ar
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Division of Vital Records, P.O. Box 68761 tal or Attending Physician: The law requires that the death certificate all Director: After this certificate has been signed by the attending phy led in by the funeral director, page 2 should be detached for use as the b	Be C	25. Was case refer examiner?	red to medic				26.Place	e of Death (Chec				
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on of Anding Ph	흲	1 Natural		nding FOUNL	h, Day,Year) D:	FOUND:		Yes 2 V No	Subject stab			n
IVISIOR or Attend after death Director:	lical	2 Accident 3 Suicide		uld not be Jul 3, 2		- At home, farm, stre	et, factory, office b	ouilding, etc.			er or Rura	al Route Number, City
Dispital of ours at ours at filled	Certification:	4  Homicide		ermined (Specify)	Single	Family Home			or Town, St 1710 N. Broad		e, Md.	
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FSFO	ž	29b. Signature and	title of entifi				29c. Licens			29d. Date signe		th, Day, Year)
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6		Laron Locke	e MD.	n who completed cau Assistant Medica	al Exam	iner 111 Peni	n Street, Baltir	more, MD 21	201			
Sta Registr	_	31. Date filed (Mon	th, Day, Year,		egistrar's S	Signature						
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Registrar

DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

ROAD

RANDALLS TOWN

SUITE

21133

3.03.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5310 OLD COURT AVVERALLE TOW

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:55 Melvin Carl Johnson July 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 705 Old Orchard Road Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X M 2 ☐ F Director 164-18-5605 85 April 7, 1922 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "netural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Harford Bel Air Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Old Orchard Road 21015 USA deeth Funeral permit. Pages 1 and 2 should be filed within 72 hours after dee Depentment of Health and Mental Hygiene. Important: It item 27 ie marked other then "netural; or lawnoorder." 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. ty Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Loan Manager Finance Company 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Melvin Pyle Johnson Winifred Olivia Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Johnson/Wife 705 Old Orchard Road Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Removal from State 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 07-12-07 Bel Air, Maryland 21. Signature of Funeral Service Licensed 22. Name and Address of Facility McComas Funeral Home, P.A., 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition **Physician** tribrovastular 1 (ar) resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as signed by the ettending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably should | Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe this certificate 2 🗌 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) STONO Medical Certification: To ₽ 1 Tyes After thi 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Accident death. М 1 ☐ Yes 2 ☐ No the I Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funerel Dire 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D74652 July 6 2007

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Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Nurth 31. Date filed (Month, Day, Year) State

Registrar

07-05287 Maryann Knapp

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Dhyminia		1. For State Registrar 1. Decedent's Name (First, Middle,Last)	Maryland	Depa Ce	artment of artificate of	f Health and f Death	d Mental		Reg. No.	UU7 223
Physicia Medical Exami	an/ nei	MarvAnn Kna	g					2. Date of Dea Month July 9, 20	ath Day Year	3. Time of Death 1902 hrs
Funeral		4a. Facility Name (if not institution, give s Atlantic General Hospital  5. Social Security Number 6. Sex				4b. City, Town, or Berlin	Location of De	ath	4c. County of Worceste	
Director		218-46-5423 <sub>1M</sub>	2X. F	(In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours M		nth(MM/DD/YYYY) 30,1946	9. Birthplace (State or Foreign Country) Md.
ow any		Usual Residence of Decedent  10a. State  10b. County  Md.  Baltimo			, Town or Locati	on				10d. Inside City Limits
h the Maryland 3a or 28a-f show oliffed at once.	Director	10e. Street and Number	ле	L	Dundalk	10f. Zip Code		1	0g. Citizen of Wha	1 Yes 2 X No
ith with the lems 23a o	Funeral D	7810 Scholar Rd.	?. Was Decedent E	ver in U.		Decedent of History	1222	Specify Vec or No	USA	American Indian, Black,
s after	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced If	Yes 2 2 es, Give Year	X No	1	Yes 2 X No	Mexican, Puer specify:	to Rican, etc.)	White,	WHite
136 hin 72 hour e than "nate dical Exar	Completed	15. Decedent's Education (Specify only holds) Elementary/Secondary (0-12) 12 yrs.	ighest grade comp College (1-4 or 5-		auring mo	s Usual Occupations of working life. I	on (Give kind of DO NOT use re	work done etired)	16b. Kind of Busin	ness/Industry
215-0036 e filed within 72 tal Hygiene ked other than nt, the Medical	Be Com	17. Father's Name (First, Middle, Last)  James Jenkins			Hous	ewife	B. Mother's Nam	ne (First, Middle, M	Home  Maiden Surname)	
AD 212 2 should b h and Ment 27 is mark		19a. Informant's Name/Relationship (Type,	Print)		19b. Mailing .	Address (Street a	and Number or	Rural Route Num	ber. City or Town	State, Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E		20a. Method of Disposition  1 X Burial 2 Cremation 3		20b. P	lace of Dispositi	Scholar I on (Name of ceme place) laus Cem	etery.	Date 14	2   222 20c. Location - Ci	ty or Town, State
Baltin permit. Pa Departmen Importan injury or	-	4 Donation 5 Other Specify: Signature of Funeral Service Specify:					•	2007	Baltim	ore —————
Physician /Medical		2/a. 9ar I. Enter the disease, or conclibeting				me and Address onelly Fundamental Sollers mode of dying, su	Point of as cardiac	Rd, 212 or respiratory arres	st, shock, or heart	Approximate Interval
xaminer	- 1	or condition resulting in death)	o (or as a consequ							Between Onset and Death
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n and - transit		events resulting in death) Last Due t	o (or as a consequ	ence of):						
68760, certificate be exect dding physician an e. as the burial - tr	1 2	F FEMALE: 23 3b. Was decedent pregnant in the	ENDED	of pregna	ancy				23d. Date of deli	Verv
Box e death e the atter ed for us	no lo fu	past 12 months?  Yes 2 No 9 Unknown 9	Live birth Pregnant at tim Unknown	e of deat	h -	death 3 (Specify)	Ectopic pregna	incy	Month	Day Year
S, P.O. uires that the signed by d be detach	3	art II. Other significant conditions contr hypertension	ibuting to death bu	t not resi	ulting in the und	erlying cause give	n in Part I.			to the cause of death?
tal Records, cian: The law require certificate has been si ector, page 2 should b. Be Completed								24a. Was an autopsy performe	24b. Were	autopsy findings available to completion of cause of
Vital Rec ysician: The his certificate I director, page	2	5. Was case referred to medical examiner?	li <sub>d</sub> Tourism	0 4 5			Death (Check o	1 Yes 2	✓ No 1	Yes 2 No
Division of Vital Ind or Attending Physician: Is after death all Director: After this certified in by the funeral director Prification: To Be	2	7. Manner of Death  V Natural 5 Pending	inipatient  ia. Date of Injury (Month, Day, Year)		R/Outpatient 3 8b. Time of Injur	y 28c. Injury at	Work?	Home 5 Re 28d. Describe hov		her:
Division of Spiral or Attending Mours after death meral Director: At filled in by the fun Certification	3	Accident Investigation  Suicide 6 Could not be	Be. Place of Injury	- At home	e, farm, street, fa	1 Yes		28f. Location (Stre	eet and Number or	Rural Route Number, City
To the Hosp within 24 hos To the Frine completely fi	(0	Da. Certifying Physician: To heke only 2 Medical Examiner: On the and m	the best of my kno	owledge,	death occurred	at the time, date a	nd place, and o		<u> </u>	ated.
To with To con	29	bb. Signature and title of certifier	anner stated.			29c. License nui	mber		d place, and due to 9d. Date signed (A	1
54	30	. Name and address of person who completed Theodore M. King, Jr., MD. A				O.C.M.E			uly 10, 2007	
State Registrar	31	Date filed (Month, Day, Year)	SSistant Medic		Monage 11	Penn Street	, Baltimore,	MD 21201		

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•	1- For State Registrar	Certificate o	f Death	Reg	. No.	1 2201
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last)			June 25, 20	Day Year 107	3. Time of Death 0715 hrs
	4a. Facility Name (if not institution, give street and 1309 Morling Avenue	number)	4b. City, Town, or Location of Baltimore	11	4c. County of Death N/A	
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 50	Months Days Hours	24Hrs. 8. Date of Birth Min. Nov. 1	(MM/DD/YYYY) 9. Birth 6,1956 Foreign Cou	
Maryland 28a-f show any 1 af ouce.	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Town or Loca Baltimore		140		10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once			10f. Zip Code 21211	100	g. Citizen of What Count USA	rry?
ter death wind or items er must be	1 Never Married 2 X Married 1 Yes 3 Widowed 4 Divorced If Yes, Give to Dr. Dates:	Forces? If ` 2 XX No 'ear 1	as Decedent of Hispanic Origin Yes, specify Cuban, Mexican, F Yes XX No specify:	Puerto Rican, etc.)	14. Race - Americ White, etc. Specify.White	
nore, MD 21215-0036 siges 1 and 2 should be filed within 72 hours afte nt of Health and Mental Hygiene.  It: If item 27 is marked other than "natural", other traumatic event, the Medical Examines To Re Commileted by		(1-4 or 5+) during r	nt's Usual Occupation (Give kil nost of working life. DO NOT u er Fitter		16b. Kind of Business/Ir Steel Manu	
21215-003 hould be filed within and Mental Hygiene. is marked other that it is count, the Med		atochvil	18. Mother's	Name (First, Middle, M Betty R		
MD 21215-0036 12 should be filed within 7 14 should be filed within 7 16 in marked other than 17 is marked other than 170 Re Commit		Wife	ng Address (Street and Numb 3644 Keystone	Avenue, Ba	ltimore, Ma	aryland
	20a. Method of Disposition  1 Burial 2 XXCremation 3 Remova  4 Dogation 5 Other Specify:	I from State crematory or o	rematory	Date 6/27/2007	20c. Location - City or Catonsvill	le, MD
Baltimo permit. Pag Department Important; injury or or	21. Include of Funeral/Service Ocensee	Mov891 Bi	Name and Address of Facility 1rgee-Henss-Se 31 Falls Road	itz Funeral , Baltimore	Home, Inc. , Maryland	. 21211
Physician /Medical :aminer		and methadone into a consequence of):		•	st, shock, or heart	Approximate Interval Between Onset and Death
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the death certificate be by the attending physici ched for use as the buri		es, outcome of pregnancy e birth 2 F	Fetal death 3 Ectopic Other (Specify)	pregnancy	23d. Date of delivery Month	Day Year
H H H H H H	â		e underlying cause given in Par	***	bacco use contribute to	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the started death and the this certificate has been signed by led in by the funeral director, page 2 should be detac				24a. Was a autop:	sy prior to o med? death?	topsy findings available completion of cause of
Vital Rec ysician: The l his certificate			26.Place of Death (	1 Yes 2	2 No 1 Y	es 2 No
ital sician; sicerti	examiner? [Hospital: .	Inpatient 2 ER/Outpatie	Other		Residence 6 V Othe	r: Scene
n of Vi nding Physi th :: After this e funeral dir		ate of Injury 28b. Time o	f Injury 28c. Injury at Work?		now injury occurred	
Division o	2 Accident Investigation 3 Sulcide 6 X Could not be determined (Spec	Place of Injury - At home, farm, str	reet, factory, office building, etc		Street and Number or Rutate) ing Ave. Balt	
Division  To the Hospital or Attent within 24 hours after death? To the Funeral Director: completely filled in by the	29a Certifier (Check only one) 2 ✓ Medical Examiner: On the bar and mann 29b. Signature and title of certifier	best of my knowledge, death occ sis of examination and/or investig	curred at the time, date and pla gation, in my opinion, death occ	ce, and due to the caus	e(s) and manner as stat	ed.
F. W. F. S	29b. Signature and tipe of certifier	MD	29c. License number O.C.M.E.		29d. Date signed (Mo June 25, 2007	nth, Day, Year)
07	30. Name and address of person who completed of Melissa Brassell, MD Assistant		Penn Street, Baltimore	e, MD 21201		
Sta Registra	31. Date filed (Month, Day, Year)  33 34 37 37 38 38 38 38 38 38 38 38 38 38 38 38 38	Registrar's Signature	nev			

9-12-07 Tracey CO F. H WILL MEHAL MEO

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

pert Edward	J LO		State of Maryland / Department of Health a For State Certificate of Death	ing Mentaring	Reg. No	Luce Sed	
Physic	ciar	7 1	gistrar Decedent's Name (First, Middle,Last)		Date of Death		3. Time of Death
dical Exam		er	Robert Edward Long, Jr.	Leasting of Dooth	July 10, 2007	4c. County of <b>De</b> at	
· V		4	a. Facility Name (if not institution, give street and number) 4b. City, Town, 1633 Parkman Street Baltimore	or Location of Death		vo. County of Boat	P
Funera		5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y		8. Date of Birth(M	Forei	rthplace (State or
Directo			213-04-4712   1X M 2 F   30 Yrs.   Months   D	bays Hours Min.	Feb. 10,	1977	ountry) MD
Or . 171		. l	sual Residence of Decedent				10d. Inside City Limits
w any			0a. State 10b. County 10c. City, Town or Location Baltimore		5		1 X Yes 2 No
Maryland 28a-f show any	tonce		De. Street and Number 10f. Zip Code	e	10g. C	Citizen of What Co	untry?
vith the Maryland s 23a or 28a-f show	ified a	ادة	1633 Parkman Street 21230	)	U.S	.A.	
with t	pe not	힏	1. Wallet States	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
death wi		11 I	Never Married 2 X Married 1 Yes 2 X No			Specify: whi	to
rs after	niner	_ھ	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occu	pation (Give kind of w		o. Kind of Business	
72 hou	al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			1	1 01
vithin ene.	Medic	du_	9 Owner/Operato		(First, Middle, Maid		l Cleaning
15-C	t, the		7. Father's Name (First, Middle, Last)	Nellie M			
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural",	c even	B	Robert Edward Long, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (S				te, Zip Code)
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leatht and Mental Hygiene. from 21 is marked other than "natural", or items 23a or 28a-f she	tumati		Heather Long/Wife 5603 Oregon  20a Method of Disposition (Name of Disposition (Name of Disposition)	n Avenue A	rbutus Md	21227 oc. Location - City	or Town, State
S S E	her tra	1	20a. Method of Disposition  20b. Place of Disposition (Name of State Burial 2 X Cremation 3 Removal from State West Artificial Cremation 2 Removal from State Removal	ematory 7-			
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Baltimo permit. Page Department o	injur	1	1328 Sul	ress of Facility Amb phur Sprin	g Rd. Arb	utus MD	21227
Physicia	an	7	3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy failure. List only one cause on each line.	ying, such as cardiac o	r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medic xamin	-	ı	Immediate Cause (Final disease a. Contact Gunshot Wound of Head				Death
			or condition resulting in death)  Due to (or as a consequence of):  b.				
	ı	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter third-rights Course				
		Examiner	C.  Due to (or as a consequence of):  Due to (or as a consequence of):				
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ian ex	burial -	sician/Medical	UNPENDED AMENDED			23d. Date of deliv	verv
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DX 6 ath cer	hed for use as the	sicia	1 Yes 2 No 9 Unknown g Unknown	)		iii	
the de	ched f	<u>&gt;</u> ∣	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.			to the cause of death?
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rds, requir	should be detached	Completed			24a. Was an autopsy	prior	autopsy findings available to completion of cause of
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f Vit	al dire	To B	1 Yes 2 No Inpatient 2 ER/Outpatient 3 Doz	. Injury at Work?	ng Home 5 Re		iner. Scene
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ivision 1 or Attend after death.	Director: I in by the	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of	ffice building, etc.	or Town Sta	te)	Rural Route Number, City
Div	filled i	Certification:	determined (Specify) Townhouse / Rowhouse		1633 Parkman	Street, Baltimore	
Di To the Hospital within 24 hours a	To the Funeral Director: After this cellulicate completely filled in by the funeral director, page	cal (	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one	me, date and place, an pinion, death occurred	id due to the cause( at the time, date ar	s) and manner as id place, and due t	stated. o the cause(s)
To th withi	comp	Medical	and manner stated.	icense number			(Month, Day, Year)
<b>-</b>		-		D.C.M.E.		July 11, 2007	
Do	V		30. Name and address of person who completed cause of death (Item 23a)		0.4		
- 1			Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 212	01		
		tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 2007	<i>p</i>			

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	State of Maryland	/ Department of He	ealth and Menta	l Hvaiene

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	Physicia	in/	Decedent's Name (First, Middle 1)	e,Last)	· · m	1011	TA	2. Date of Deal Month	Day Year	3. Time of Death 1102 hrs
Med	dical Exami		William Co.	NF.		CBE+h	y, Town, or Location of I	July 8, 200	4c. County of De	
			4a. Facility Name (if not institutio 3123 Windsor Blvd.	n, give s	treet and number)		ynn Oak	Scatt	Baltimore C	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las		Inder 1 Year If Under 2		th (MM/DD/YYYY) g.	Birthplace (State or reign
	Director		229849517	1 X N	1 2 F 52	Yrs.	nths Days Hours	Min. 6/13		Country) / A
10-54			Usual Residence of Decedent  10a. State 10b. County		10c City T	own or Location		7 /		10d. Inside City Limits
	ow any		mig Ral	1 . 1	ORF GW	Ynn	DAK			1 Yes 2 No
3	rrylanc 8a-f sh at onc	ctor	10e. Street and Number	1/1	on ow		Zip Code	1	0g. Citizen of What C	ountry?
7	death with the Maryland or items 23a or 28a-f show nust be notified at once.	Funeral Director	3/23 Winds	OR	Blud		21207		USA	
0	h with ms 23 be no	eral	11. Marital Status  1 Never Married 2 MM		12. Was Decedent Ever in U.S Armed Forces?		edent of Hispanic Origin ecify Cuban, Mexican, F		14. Race - An White, etc	nerican Indian, Black,
	er deat , or ite	Fun			1 Yes 2 No Yes, Give Year	1 Yes	aut.		Specify: B	IACH
	urs,aft tural" amine	dby	15. Decedent's Education (Spe		r Dates:	16a. Decedent's Us	ual Occupation (Give kir		16b. Kind of Busine	ss/industry
	5 72 ho m "na	leted	Elementary/Secondary (0-12)	Т	College (1-4 or 5+)	-	working life. DO NOT us	se retired)	Onein L	100
	within jene.	Comple	unk.	11.74		TRUCK		Name (First, Middle,	Maiden Surname)	RANSTER
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	212 nould be id Ment is mark tic even	TOE	19a. Informant's Name/Relations	hip (Typ	e, Print) DAUG h 1ER	11 6 . 7	ess (Street and Numb		•	tate, Zip Code)
	e, MD 1 and 2 sho Health and Titem 27 is r traumati		TAWANDA	) <u>[</u>	ABORN	lace of Disposition (		EmfoRil	7 UH X	3 ) 9 /
	= s 4 = 3		20a. Method of Disposition  1	3 🕽	Damarral from State	ematory or other pla	ace)		''	
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	Balti permit Departu Import injury		Phillo AW each	nto		Ph:11.		ER FRA FI	5 2431	FOINER SY
	Physician	-	23a. Part I. Enter the disease, or fallure. List only one cause	complic	cations that caused the death.	Do not enter the mo		diac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
	/Medical caminer		Immediate Cause (Final disease	a	Hypertensive athe		cardiovascula	ar disease		Death
	Source of the Source		or condition resulting in death)	b.	ue to (or as a consequence of)	i:				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		ue to (or as a consequence of	:		K JI		
	ı,	Examiner	(Disease or injury that initiated events resulting in death) Last	С	ue to (or as a consequence of)	1:	-			
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	760, cate be execut physician and he burial - tra	Medical	XUNPENDED	X	#F,23a,27,perME,		07 TT		23d. Date of deli	Nerv
	1876 Tificati ing phy as the		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he	23c. If yes, outcome of pregnt 1 Live birth	2 Fetal de	eath 3 Ectopic	pregnancy	Month Month	Day Year
	ox 6	Physician	1 Yes 2 No 9 Un	known	4 Pregnant at time of deag	ath 5 Other (	Specify)			
	D. B the de by the	Phy	Part II. Other significant condi	tions (	contributing to death but not re	sulting in the under	lying cause given in Par	t I. 23e. Did	tobacco use contribut	e to the cause of death?
	P.C res that signed be deta	d by					· <del></del>	1 Ye	es 2 No 3	Probably 4 Unknown
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	tal Reco rian: The law certificate has ector, page 2 s	omp		•				1 🗸 Yes	ormed? deat 2 No 1 ✔	h? Yes 2 No
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	f Vit Physic er this ral dir	ဥ	1 Yes 2 No 27. Manner of Death		28a. Date of Injury	ER/Outpatient 3 28b. Time of Injury	DOA Other 4 28c. Injury at Work?	Nursing Home 5 28d. Describe	Residence 6 🗸 C	Other: Scene
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	Division pital or Attent ours after death neral Director: filled in by the	fical		stigation	28e Place of Injury - At ho	me, farm, street, fa	ctory, office building, etc	. 28f. Location or Town,		r Rural Route Number, City
-	Division  Hospital or Attence 24 hours after death Funeral Director: stely filled in by the	Certification:	4 Homicide dete	rmined	(Specify)					
_	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the timeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying F	hysicia miner:	<ul> <li>n: To the best of my knowledg</li> <li>On the basis of examination ar</li> </ul>	e, death occurred and/or investigation, i	it the time, date and place in my opinion, death occ	ce, and due to the cau curred at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)
#	To the within 7 To the complet	Medical	29b. Signature and title of certifi		and manner stated.		29c. License number			(Month, Day, Year)
		_	701	1 #	12		O.C.M.E.		July 9, 2007	
	(6)		30. Name and address of person	1 who co	empleted cause of death (Item					
					tant Medical Examiner		treet, Baltimore, M	ID 21201		
	S Regis	tate trar	1111	12	32. Registrar's Signatu	re Ace	March 1			
_		_				. 4				

	•	State of Maryland / Dep	ertment of Health and Nertificate of Death		ene2007 22381
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physicia /Medic		Elizabeth Anna Moyer		July !	5, 2007 2:05P M
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	·	4c. County of Death
		2006 Waverly Drive	Bel Air		Harford
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day,	9 Birtholace (State or Foreign
Director		177 <b>-</b> 24-6244 1□ M 2\(\overline{\ov	World Days Flours Will.		1928 Pennsylvania
pu s	ŀ	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	agation		10d. Inside City Limits
show ad at	5				1 Tyes 2 XNo
the M.	Director	Maryland Harford Bel Air		40	
h with 1	al Dir	2006 Waverly Drive	10f. Zip Code 21015	10	g. Citizen of What Country?  USA
030 urs a	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spt tf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
5-003	Completed		edent's Usual Occupation	1	6b. Kind of Business/Industry
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Iryland 2121 should be filed withir nd Mental Hygiene. marked other than matic event, the Me	LOC I		Iomemaker		Own Home
nd 2 be filed al Hygin t other	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	aiden Sumame)
ylane ould be Mental Marked o	2	John (u/k) Vuxta	Mary	(u/k)	Szada
2 sho and I		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Run	al Route Number,	City or Town, State, Zip Code)
C = 44 F		Cyrus D. Moyer, Sr Husband 2006	Waverly Drive, Be	el Air, M	ID 21015
altimore, mit. Pages 1 at portent: if item y injury or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, cre	osition (Name of ematory or other place)	Date 2	0c. Location - City or Town, Slate
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m 82529		Mules amy	0 W. Broadway, Be	L Air, MD	21014
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/Medical		resulting in death)  Due to (or as a consequence of):	7009		E
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IS, Faires tha	۵	A / / N O TO O A C O STATE of	indenying cause given in Pa(1).		
w requir	eted	agree car certical		1 Tes	3 Probably 4 Unknown
Pec elaw has b	ם	Claute renal insi	Hicana	24a. Was an autopsy	prior to completion of cause of
The Tage	Completed	e Al		perform 1 Yes 2	ed? death? ☐No 1 ☐ Yes 2 ☐ No
of Vital F Physician: Th this certificate ral director, pag	Be B	25. Was case referred to medical examiner?		h (Check only one	
Of \Physical Physical this of rail directions of the control of th	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5X Residen	nce 6 ☐ Other (Specify)
ding P h. After funera	ë	27. Manner of Death 28a. Date of Injury 28b. Time of Month, Day Year) Injury Injury	Work?	28d. Describe how	vinjury occurred
VISION Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division of Vital Records, I or Attending Physician: The law requires ta after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be to	Certification:	4 Homicide  4 Homicide  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
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Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier (Check only onle)  1 ☐ Certifying Physicien: To the best of my knowledge, dea 2 ☐ Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, exestigation, in my opinion, death occurr	and due to the cau red at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
vithin o th ompl		29b. Signature and title of contriber	29c. License number	29	d. Date signed (Month, Day, Year)
~ × ·		D/D/X2	Nonnil o	G	7-1-07
, A Y	-	30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 200 366 Y	57	1-0-01
10		De Ann Osman 520 Upper	Ches Dr BelF	tie. Li	d 71014
State	e	31. Date filed (Month, Day, Year) 32. Togistrar's Signature	-1000		W =1011
Registra		1111 1 5 2007 A. A. A.	make 1		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9, 2007 11:15 A M Ernest Brodey Nuttall July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 205 E. Joppa Road Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 XM 2 ☐ F 99 Jan. 10, 1908 Director 220-36-6891 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits fshow "natural", or items 23a or 28a-f shov digal Examiner must be notified at 1 ☐Yes 2 No Directo MD Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with t 205 E. Joppa Road #1707 21286 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within in and Mental Hygiene. 7 Is marked other than "r Dental School/ Elementary/Secondary (0-12) College (1-4or 5+) Dentist Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Nuttall Sadie Caulk ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2. Department of Health a Important: If item 27 Is any Injury or other trau William E. Nuttall/Son 14202 Sagewood Road Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park July 17, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2007 Baltimore, MD Cemetery rvige Ligunsee Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 21. Signature of Amera Michael J. Flagle e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Fart1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) w /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transi Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician; Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury (Month, Day Year) 5 Pending 1 □ Yes 2 □ No investigation 2 Accident after death in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 🛙 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 101 CONN 31. Date filed (Month, Day, Year) State Registrar

5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 😡 F 087-22-6968 78 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10a. State 10b. County Maryland | Montgomery Director 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be n 11816 Eton Manor Place #103 Funeral 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be NOT AVAILABLE f Health au m 27 is m. 19a. Informant's Name/Relationship (Type. Print) William Nishan / Husband permit. Pages 1 and Department of Health Important: if item 27 any Injury or other tr once. 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the diseas shock, or hear failure. Immediate Cause (Finar-disease or condition resulting in death) OWER **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No been signed by the should be detached 9 Unknown Completed by To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Yes 2 No P 1X Inpatient this funeral 27. Manner of Death 28a. Date of Injury Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 2 Accident after death Director: 6 Could not be 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a, Certifier Medical (Check only one) Signature and title of certifie

**Physician** 

/Medical

Examiner

For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month KLEN MAHPI 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 5, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Michigan 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Germantown 10g. Citizen of What Country? 10f. Zip Code 20876 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No Specify: Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Medical Office Administrator Orthopaedic Surgeon's Office 18. Mother's Name (First, Middle, Maiden Surname) Louise Shaninian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11816 Eton Manor Place #103, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Montgomery Crematorium, Inc. July 10, 2007 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death BEEDING GASTROINTESTINAL Due to (or as a consequence of): MONTH DENO CARCINOMA OF THE Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 0850 of death (Item 23a) (Type, Print) 9707 MEDICAL CENTER 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

		State of Maryland / E				lental Hyg	iene		
		Registrar	Cer	tificate of L	Jeatn		eg. No.		10.000
Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deal		Year	3. Time of Death
/Medic		Louise L. Oertly				July 9			9:30 P M
Examin	er	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Clinto	Location of Death			y of Death ince	George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	thday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Aug 10,	<sup>Year)</sup> 1923	9. Birthr	place (State or Foreign ntry) yland
p		Usual Residence of Decedent							
arylar show dat	_	10a. State 10b. County 10c. City, Town						1	10d. Inside City Limits
ne Ma 8a-f	Director	Maryland Prince George's Fore	stvi	T		- I			1 □ Yes 2 □ No
vith th		10e. Street and Number		10f. Zip Code	20747		<sup>0g. Citizen of</sup> United		•
eath v	era	7700 Kipling Pkwy  11 Marital Status 12. Was Decedent Ever in U.S.	12 14	1				ce - Americ	
hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	y Funeral	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No   Yes Give A		Yes, specify Cuba	spanic Origin? (Spo in, Mexican, Puerto Specify:	Rican, etc.)	Bla	nck, White,	
72 hours natural" lical Exa	ted by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a.	Deced	ent's Usual Occupa	ation	ina	16b. Kind of E		dustry
within in intene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		naker	during most of work )	ng	Own I	Home	
offiled I Hyg other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, I			
uld be Menta Irked	To E	George Lincoln			Louisa	Mohr			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Martal Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.					and Number or Run Pkwy, For				Code)
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nit. Pa artme ortani Injury		4 □ Donation 5 □ Other (Specify) Mary  21. Sign tup of Funeral Service (in Ansee			s Cemeter Ss of Facility Lee				Maryland
permi Depai Impoi any Ir		Mario Heart moods?			Ferry Ro				
		23a Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	r the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition	2/4	17744					Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence	of):	6	=01101	2 C		-	2 Car Che
	ē	if any, leading to immediate  b. Due to (or as a consequence	of):	7	FUNCE			- 4	2 CUEEKS
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Pn	FUNCE	NIA			2 WEEKS
cate be executed hysician and the burial-transit		resulting in death) Last  Due to (or as a consequence of	of):						
sate ohys	edical	d							
eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □Live birth 2 □ Fetal death	, a 🗆	Estania programa			23d. D	ate of deliv	ery
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			M	lonth	Day Year
res that the de signed by the a		Part II. Other significant conditions contributing to death but not resulting in	n the un	derlying cause give	en in Part I.	23e. Did to	pacco use cor	ntribute to t	he cause of death?
v requires been sign should be	ed by	DELARATIA				1 ☐ Y	es 2 No	3□ Prol	bably 4 □Unknown
has be	Completed					24a. Was a autops	n 24b	prior to co	ppsy findings available impletion of cause of
		OF Was ages referred to medical					ned? 2 M No	death? 1 ☐ Yes	2 □ No
s certi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	itnation	3 DOA Othe	26. Place of Deatler:	n <i>(Check only on</i> me 5 ☐ Reside		har (Canal	4.1
Attending Physician: death, ector: After this certification with the funeral director,	ا: 1	27. Manner of Death 28a. Date of Injury 28b.	Time of	28c. Injury Work		28d. Describe h			19/
ath. r: Aft	atio	1 Matural 5 □ Pending (Month, Day Year) I 2 □ Accident investigation	njury		Yes 2 □ No				
after deta Blrecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	ırm, stre	et, factory, office		28f. Location (Si City or Town	reet and Num n, State)	ber or Rur	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.							
ro the vithin 2 ro the comple	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License	e number	_ 2	9d. Date sign	ed (Month,	Day, Year)
FSFO		· Me	7	10-1	18545	-	ruly	19	2007
O		30. Name and address of person who completed cause of death (Item 23a)	(Type, F	Print) OU)	LINE C	ENTE	r w	AUE	r.F. Md.
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and in	7)					20602
			10	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 9:25 PM July 6, Florence Rita Oktavec /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Ye Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Year Days Hours Months Min. 1 □ M 2 🗙 F 1919 Maryland Director 87 213-01<del>-</del>1193 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County r 28a-f show notified at 1 XYes 2 No Directo Harford Bel Air <u>Maryland</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e items 23a cliner must be 21014 USA 403 Harlan Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2/2 No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Assistant Medical Research 8 Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, <u>th</u> once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony (nmn) Kuczynski Aleksandra (nmn) Sumcwski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Boh Oktavec / Son 2302 Red Stone Ct., Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial /2 □Cremation State 4 □ Dogation 5 □ Other (Spegity) 7-11-07 Baltimore, Maryland Gardens of Faith McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, Maryland 21009

Approximate disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate distances. 22. Name and Address of Facility 21. Signat of Funeral 23a. Immediate Cause (Final disease or condition resulting in death) **Physician** conon /Medical Due to (or as a consequence of): Examiner Due to or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Be Certification: To

M800313394 law requires that the death certificate be executed O. Box 68760, physician ģ Records, - lorenc Vital the Hospital or Attending Physician: Division or After this charec within 24 hours after death.

To the Funeral Director: Af

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

						1 Yes 2	No 3 Probably Unknown
					<del></del>	24a. Was an autopsy performed? 1  Yes	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical				26.	Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 <b>∑X</b> No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient	3□ DO	A Other: 4	□ Nursing H	lome 5 Residence 6	□Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street	t, factory	, office			Number or Rural Route Number,
	ysician: To the best of my kno niner: On the basis of examina						and manner as stated. place, and due to the cause(s)

State

Medical

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOG 36487

Bentman 500 Year

31. Date filed (Month, Day,

29b. Signature and title of certified

32. Registrar's Signature

Registrar

			1 - For State Registrar	State of Man	•	artment of I		, ,	giene eg. No.	7 22365
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10.00	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	th	4c County of D	eath
		щ	5. Social Security Number & Se	7 Age (1)	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Carra	Distribution (State or Foreign
	Funeral Director		501-18-8048	XM 2□ F / Ng 8 ("	82 Yrs.	Months Days	Hours Min		1925 No	Birthplace (State or Foreign Country) Orth Dakota
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	show	2	10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
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	3a or	Funeral Director	409 Chapelwood L	ano			093			S.A.
	death ms 2	nera	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.			Specify Yes or No- to Rican, etc.)		merican Indian,
9	after or Ite	/ Ful	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		ii Yes, specity Cub 1 ☐ Yes 2 【 No	an, Mexican, Puer Specify:	to Hican, etc.)		/hite, etc.
21215-0036	hours turel',	d by	3 ◯XWidowed 4 □ Divorced	Year or Dates:					Specify:	White
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p	be filed within 72 hours after death with the Maryland at Hygiene. A letter 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
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Maryland	d 2 st th and 7 is n treum	V A	19a. Informant's Name/Relationship (T)						City or Town, Stat	
	Health Health tem 27 other tr		William Pederson  20a. Method of Disposition	S0n	20b. Place of Dispo cemetery, crer	ep Run Co		t valley,	Maryland 20c. Location - City	
Ď.	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐XF 4 ☐ Donation 5 ☐ Other (Specify)	idilioval libili State	Oakwood (		1	4-2007	Lisbon	North Dakota
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dependent of Health and Mental Hygiene. Important if them 27 is marked other than "naturel; or ttems 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signator of Fune al Service Licens			2. Name and Addre				Home, Inc.
<u> </u>	88 5 8		Tank Ottagan		10	50 York		owson, Ma		21204
P			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the ne cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
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ă	death a atter d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	Day Year
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Records, P.O. Box	se vig	þ	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tot		e to the cause of death?
ord	w require been si should b	Completed						1 🗆 Ye	s 2000 3 □	Probably 4 Unknown
3ec	has b	d E						24a. Was a autops	n 24b. Were	autopsy findings available completion of cause of
a	ician: Th certificete rector, peç	ပို	OF Man ages referred to madical						No 1□Y	es 2□ No
5	Physician: this certificeral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 ER/Outpatien	t 3 DOA Oth		ath Check only on	e) ence 6 ⊡Other <i>(S</i>	
0	ding Physician: The n	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of				ow injury occurred	респу)
Sioi	Attending ir death. ector: After by the fune	catlo	1 Natural 5 Pending 2 Accident investigation	(,,,			Yes 2 □ No			
Division of Vital	or Attendent efter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (St City or Town		Rural Route Number,
_	spital ours ours illed		29a. Certifier 1 Certifying Phys	sician: To the best of m	v knowledne death	occurred at the tir	ne date and place	and due to the or	ausols) and manner	as stated
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Examinate)	ner: On the basis of exa and manner stated.	amination and/or inv	estigation, in my o	pinion, death occi	urred at the time, da	ate and place, and o	due to the cause(s)
	To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by	ž	29b. Signature and title of certifier	m ( asser		29c. Licens			9d. Date signed (Mo	
)				7			059943		July 111	2007.
	15		30. Name and address of person who co	- 64 -	(Item 23a) (Type,	Print)	ite 357	ceshnin	ster M.	21157.
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1200)	0115 / 1	- // / / / /	7] /	11)/
	Registra		JUL 1 2 2007	Bloom	& Span					

		,	1 - For State Amend Item		dr.,g86	Servificate 87	Death			22337				
	Physici	an	1. Decedent's Name (First, Middle, Last)		t	Du	ILIP	2. Date of Dea Month	Day Year	3. Time of Death 103°, 25 AM				
	/Medio		BLANCHE 4a. Facility Name (If not institution, give	street and number)	<i>t</i> .		r Location of Death	JULY	4c. County of Dea	7				
		4	JOHNS HOPKINS BAYU			- Audi	MORE		N/A					
	Funeral Director		215 32 /334	x 7. Age (i ] M 2 ☐ <b>X</b> F	In yrs. last birth	day) If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day July 2	9. Bir 2, 1935 Ma	thplace (State or Foreign ountry) aryland				
700	ow it		Usual Residence of Decedent  10a. State  10b. County	10	0c. City, Town	or Location				10d. Inside City Limits				
Man	a-f sho	tor	Maryland Balti	more	Dunda	alk				1 ∐Yes 2 D <b>X</b> No				
th th	or 28%	Funeral Director	10e, Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?				
at the	s 23a	eral	2963 Yorkway	12. Was Decedent Eve	or in II S		L222	ocify Voc or No	U.S.A.	orican Indian				
aryland 21215-0036	performer, rages i rains a should be fined within 72 flours after beauti with the maryral performent of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	3 111 0.3.	13. Was Decedent of Hif Yes, specify Cub  1 ☐ Yes 2 ☒ No	Specify:	Rican, etc.)	Black, Whit	te, etc.				
2-0-2	'natur dical i	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. [	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	ation during most of work	ing	16b. Kind of Business	/Industry				
21215-0036	giene.	Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker	d)		Own I	Home				
pue	ntal Hy ed oth event	Be (	17. Father's Name (First, Middle, Last)  Tvan	Rakor			18. Mother's Name Rose1		Maiden Surname) not availal	10)				
Maryland	marke matic	은	19a. Informant's Name/Relationship (Ty		19b. l	Mailing Address (Street			er, City or Town, State, .					
Ma Ma	ealth ai n 27 Is ner trau		Dennis Philip /			963 Yorkway			ryland 2122					
ore	If item		20a. Method of Disposition  1. ☑ Burial 2 ☐ Cremation 3 ☐ F		cemetery	Disposition (Name of crematory or other pla	ce)	Date	20c. Location - City or	Town, State				
Baltimore,	t. Pages rtment of H rtant: If ite njury or of	4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 7/9/2007 Baltimore,												
Ba	Depar Impor		21. Signature Funeral Service Licensee  22. Name and Address of Facility Gonce Funeral Service, P. 4001 Ritchie Highway Baltimore, Maryland											
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the ne cause on each line.	e death. Do no			or respiratory ar	rest,	Approximate Interval Between Onset and Death				
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. RESPIRA Due to (or as a c		TEIL	Sepsis			10 HOURS				
E	xaminer		Cognestially liet conditions	CARTY	SHOC					4 DAYS				
	sit of	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause. (Piecese or Iriling	Due to or as a c	onsequence of	j:								
) year	al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of	):								
68760,	physician and the burial-transit	dical		d					Lapana.	-				
	as ag		IF FEMALE:											
). Box (	igned by the attending pt be detached for use as t	by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf   1□Live birth 2 [ 4□Pregnant at tim 9□Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	/		23d. Date of de Month	livery Day Year				
О. д	d by the	, K	9 🗆 Unknown	old of iki own										
E .		0.	Part II. Other significant conditions con	ntributing to death but n	not resulting in t	he underlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?				
ords	en signed		Part II. Other significant conditions con	ntributing to death but r	not resulting in t	he underlying cause giv	en in Part I.	23e. Did to	/	o the cause of death?				
Records	as been s 2 should		Part II. Other significant conditions con	ntributing to death but r	not resulting in t	he underlying cause giv	en in Part I.	1 🔲 Y 24a. Was autop perfo	res 2 12 No 3 P					
ital Records, P.O	ate has been s page 2 should	Completed	25. Was case referred to medical	ntributing to death but r	not resulting in t	he underlying cause giv		1  Yasa autop perfor	res 2 12 No 3 □ P  an sy rmed2 death? 2 1 □ Yes	robably 4 Unknown  utopsy findings available completion of cause of				
or Vital Records	is certificate has been s director, page 2 should	o Be Completed	25. Was case referred to medical examiner?	Hospital: 1 <b>W</b> Inpatient	not resulting in t	oatient 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	24a. Was autop perfor 1 Yes	res 2 12 No 3 □ P  an sy rmed2 death? 2 1 □ Yes	robably 4 Unknown utopsy findings available completion of cause of				
or Vital	this certificate has been sral director, page 2 should	To Be Completed	25. Was case referred to medical examiner? 1 □ Yes 2 No   F	Josnifal:	2	patient 3 DOA Other	26. Place of Deat er: 4 ☐ Nursing Ho y at	24a. Was autop performing the Check only or one 5 🗆 Resident	res 2 12 No 3 □ P  24b. Were al prior to death? 22 No 1 □ Yes	robably 4 Unknown utopsy findings available completion of cause of				
or Vital	this certificate has been sral director, page 2 should	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	Hospital: 1 Manpatient  28a. Date of Injury (Month, Day Y	2 □ ER/Outp	patient 3 DOA Other	26. Place of Deat er: 4 □ Nursing Ho y at k? Yes 2 □ No	1 □ Y  24a. Was a autop performent of the control o	an symmed? 24b. Were an prior to death? 2 No 1 Yes	robably 4 Unknown  utopsy findings available completion of cause of 2 No				
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or Vital	4 hours after death.  Funeral Director; After this certificate has been s tely filled in by the funeral director, page 2 should	Certification: To Be Completed	25. Was case referred to medical examiner?  1  Yes 2 No   1    27. Manner of Death  1 Natural 5  Pending investigation  3  Suicide 6  Could not be determined  29a. Certifier 1  Certifying Physical Processing Could not be determined	Hospital: 1 Manpatient 28a. Date of Injury (Month, Day Y 28e. Place of injury building, etc. (	2 ☐ ER/Outpear) 28b. Tii Inj - At home, farn Specify)  ny knowledge, tamination and.	patient 3 DOA Other DOA Work Work M 1 DOA No. street, factory, office death occurred at the times.	26. Place of Deat er: 4 ☐ Nursing Ho y at k? Yes 2 ☐ No	24a. Was a autop performent of the performance of t	an symmed? 24b. Were an prior to death? 2 No 1 Yes	robably 4 Unknown  utopsy findings available completion of cause of 2 No  ccify)  ural Route Number,				
or Vital	after death.  Director: After this certificate has been s in by the funeral director, page 2 should	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y 28e. Place of injury building, etc. (sician: To the best of ner: On the basis of exand manner states	2 ☐ ER/Outpear) 28b. Tii Inj - At home, farn Specify)  ny knowledge, tamination and.	patient 3 DOA Other DOA Work Work M 1 DOA No. street, factory, office death occurred at the times.	26. Place of Deater: 4 □ Nursing Hoyat k? Yes 2 □ No  me, date and place, ppinion, death occur	24a. Was a autop performent of the performance of t	an sy 24b. Were an prior to death? 22 No 1 Yes ne)  dence 6 Other (Spenow injury occurred)  Street and Number or River, State)	robably 4 □Unknown  utopsy findings available completion of cause of  2 □ No  utify)  ural Route Number,  s stated. e to the cause(s)				
or Vital	4 hours after death.  Funeral Director; After this certificate has been s tely filled in by the funeral director, page 2 should	Certification: To Be Completed	25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death  1   Natural   5   Pending investigation  3   Suicide   6   Could not be determined  29a. Certifler (Check only one)  29b. Signature and title of certifier	Hospital: 1 Minpatient 28a. Date of Injury (Month, Day Y) 28e. Place of injury building, etc. ( sician: To the best of more: On the basis of exand manner stated	2 ☐ ER/Outp ear) 28b. Tii Inj - At home, farn Specify)  ny knowledge, amination and	patient 3 DOA Other me of ury M 28c. Injury Wor 1 not	26. Place of Deater: 4 □ Nursing Hoyat k? Yes 2 □ No  me, date and place, ppinion, death occur	24a. Was a autop period  1  Yes  h (Check only or one 5  Residence	an sy 2 No 3 P P P P P P P P P P P P P P P P P P	robably 4 Unknown  utopsy findings available completion of cause of 2 No  rcify)  ural Route Number,  s stated. e to the cause(s)				
or Vital	4 hours after death.  Funeral Director; After this certificate has been s tely filled in by the funeral director, page 2 should	Medical Certification: To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28e. Place of injury building, etc. ( sician: To the best of exand manner stated  MD  completed cause of deat	2 ER/Outpear) 28b. Tilling  - At home, farm Specify)  ny knowledge, amination and d.	patient 3 DOA Other me of ury M 28c. Injury Wor 1 not	26. Place of Deater: 4 Nursing Hory at k? Yes 2 No	24a. Was a autop performent of the control of the c	an sy remed? 24b. Were an prior to death? 1 Yes.  Anne)  dence 6 Other (Special Control of the c	utopsy findings available completion of cause of 2 No noisy)  ural Route Number,  s stated. e to the cause(s)  th, Day, Year)				

DHMH 17 Rev 1/2001

			1 - State Registrar	State of Marylar			ent of Health ar ate of Death	nd Mental	Hygier Reg. I	6.011	7.2.33
	Physici /Medic		1. Decedent's Name (First, Middle, Last) $James \qquad \qquad H  .$	Rog	ers			2. Date Mont Jul	of Death h y 8,	Day 2007	3. Time of Death 7:10PM M
	Examir		4a. Facility Name (If not institution, give s 9906 Frank Tippe				y, Town, or Location of per Marlbor			4c. County of Death Prince Ge	orges
	Funeral Director		5. Social Security Number 6. Sex 147–34–1966	7. Age (in yrs. 64	last birthday) Yrs.	If Und Month	ler 1 Year   If Under 24 s Days Hours	Min. (Mon	of Birth th, Day, Yea	9. Birthp Cour 1942 New	olace (State or Foreign http) Jersey
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. C	ty, Town or Lo	ocation				1	0d. Inside City Limits
	8a-f el	ctor	Maryland Prince Ge	eorge's	Fort		ington				1 ☐ Yes 2 ☐ No
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Director	10e. Street and Number 6336 Rosecroft Dri	.ve		1	Zip Code 0744		10g. (	Citizen of What Cour U.S.A	-
036	be filed within 72 hours after death with the Marylar tal Hygiene d other then "neturel", or iteme 23a or 28a-f ehow event, the Medical Exat arrmust be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Agned Forces? 1 M Yes 2 No 19 If Yes, Give Year or Dates: 19	03-		eedent of Hispanic Origin becify Cuban, Mexican, I 2 No Specify:	n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Americ Black, White, Specify: Whi	etc.
9500-6121	within 72 ho ene. then "netur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation completed)  College (1-4or 5+) 2.+	(Give	kind of t DO NOT	sual Occupation work done during most of use retired) ce Engineer			Kind of Business/In	dustry
land 2		Be	17. Father's Name (First, Middle, Last)		TIALITE	Clian	18. Mother's	s Name (First, M	liddle, Maid	en Sumame)	.accway
~	should nd Men marke imatic	<u>ب</u>	Henry James Rogers  19a. Informant's Name/Relationship (Type		19b. Mailir	na Addre	ss (Street and Number	orothy	Clar		Code) 00750
, <b>Za</b>	1 and 2 s Health ar em 27 le		Jackie Roe (Sister	.)	6843	01d	Solomons I		d. #9	2 Friends	nip, MD
More	2 4 2 0		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, creme e Crem			11y 12,		Location - City or To inton, Ma:	
Баітітоге	permit. Page Depertment of Important: If eny Injury or once.		21. Signature of Funeral Service Linese	1	22	. Name	and Address of Facility Old Alexan	Lee Fu	neral	Home, Inc	2.
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the dea							Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardio Pul	mona	ry 6	usert				Onset and Death
	death certificate be executed xx entending physicien and mod for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consect of the conse	al R+.	Pir	form Senn	u, adv	'an ar		
O. 200x 0	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	ıl death 3□	Ectopic Other (	pregnancy specify)			23d. Date of delive Month	ory Day Year
Cords, P	requires that the	ρ	Part II. Other significant conditions cont	nbuting to death but not res	sulting in the u	nderlying	cause given in Part I.	23e.	Did tobacci	o use contribute to the	ably 4 Dunknown
	The law receled has bee page 2 short	Completed							Was an autopsy performed?	prior to condeath?	psy findings available impletion of cause of 2 No
V   [2	sicien certifi irector	o Be	25. Was case referred to medical examiner?	espital:	158/0		Out.	f Death Check		- Sie	tors
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atten this certificete has completely filled in by the funeral director, page 2 or	atlon: To	1  Yes 2 No Proceed to 1 No Pending 2 Accident	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?			6 <b>ਯੂ</b> Other <i>(ਤਿਸੁਚਦੀ)</i> jury occurred	ters Residence
DIVISION	tal or Atters as all Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, facto	ory, office		ion (Street or Town, Sta	and Number or Rura ite)	l Route Number,
	Ne Hospi 124 hou Ne Funer Hetely fill.	edicai	29a. Certifier (Check only one)  1XXCertifying Physical Check only one)	cian: To the best of my known: On the basis of examination and manner stated.	owledge, death	occurre vestigation	d at the time, date and pon, in my opinion, death	place, and due to occurred at the	the cause time, date a	(s) and manner as si nd place, and due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	2		2	9c. License number		29d. C	Date signed (Month,	Day, Year)
1	X		30. Name and address of person who con	onleted cause of death //-	n 22a) /T	Drice\	D000916	2	1 7	-9-07	
(	l		Jafar Nazemian	M.D. 6196 C	XON H:	112	1 td 2 50 0x	11 H 40	L, ma	. 70745	
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	0			,		

			For State Registrar	State of Maryla	•	artmen rtificate			ind Me		iene 19. No.	007	2239)
			1. Decedent's Name (First, Middle, Last)						2	Date of Deat	h Day	Year	3. Time of Death
	Physicia /Medic		Luzenie W. Ridd:	ick						July 7,	2007		3:57 P M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location o	f Death		4c. Co	unty of Deati	1
			Fort Washington Ho					shing			Pri		eorge's
	Funeral		5. Social Security Number 6. Sex	14 of 77 =	rs. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birti	nplace (State or Foreign untry) ginia
	Director		579-44-4290 Usual Residence of Decedent	M 2MF 94	115.				P	10V. O,	1912	VIL	gillita
	land W		10a. State 10b. County	10c.	City, Town or Lo	cation							10d. Inside City Limits
	Mary f she	ō	Maryland Prince Ge	eorge's F	ort Was	hingt	on						1 ☐ Yes 2 ₺ No
	28a	Director	10e. Street and Number			10f. Zip				10	0g. Citizer	of What Co	untry?
	3a or	Ö	12604 Prestwick Dr:	ive		20	744				U.S.A	۸.	
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "netural; or Items 23a or 28s-f show event, the Medical Example in the Loutille I at	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Speci , Puerto Ri	fy Yes or No-	14.	Race - Ame Black, White	
9	or Ite	교	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes			, 7 40110 111	oan, oto.,	Sr		
21215-0036	ours Fail,	d by	3 ¼ Widowed 4 ☐ Divorced	Year or Dates:		, , , , ,						BT	ack
5-	72 h netu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	kind of wo	rk done d	uring most	of working		16b. Kind	of Business/	Industry
121	within ne.	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT ús					0.77	n Home	
22	filed with Hygiene. other ther ent, Itte N		17. Father's Name (First, Middle, Last)		nome	maker		18. Mothe	r's Name (	First, Middle, M			
and	ould be f Mental I arked o	Be	William Mitchell V	Jahh						lerson			
Maryland	should by	ဥ	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address	(Street a			Route Number	City or To	own, State, Z	lip Code)
<u>≅</u>	and 2 sho ealth and n 27 Is m			(Daughter)						Washi			
<u>6</u>	- I 5 5	1	20a. Method of Disposition	200	p. Place of Dispo cemetery, crei				Da			tion - City or	
Baltimore,	permit. Pages Department of I Importent; if it any injury or o		1 X Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)		errysto				//14/0	17	Chatl	nam, V	A
≣	permit. Pag Department Importent; any injury c		21. Signature of Funeral Service License	-		Ch 2. Name an			y Mi	ller Fu			
ä	permit. Departr Importe any inju		of tennin 12	Unice	P	0 Вох	423	, Gre	tna,				
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Undertying	Due to (or as a cons	sequence of:	(Pin)	6				301,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	ive He sequence of):	ent	+L	ربال	<u> </u>				
.O. Box	that the death certificat led by the attending phy detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 3 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	⊒Ectopic pr ☑ Other <i>(sp</i>					230	d. Date of del Month	ivery Day Year
rds, P	The law requires that the ste has been signed by th page 2 should be detache	þ	Part II. Other significant conditions cor	tributing to death but not	resulting in the u	nderlying c	ause give	en in Part I.		1	oacco use es 2K1		the cause of death?
Vital Records,		Completed								24a. Was a autops perform	v	24b. Were au prior to death? 1 \square Yes	topsy findings available completion of cause of 2 No
/ita	Physicien: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	le coutels			Oth	200		Check only on			
of	Physi this c	2	TES ZEANO	and the second s	PER/Outpatien 28b. Time of			4 🗀 140		e 5 ☐ Reside			cify)
n	Jing Ph J. After th funeral	on;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	) Injury	M A	8c. Injury Work	rat ∢? Yes 2.⊟I		d. Describe no	ow injury c	ccurred	
Division	death death ctor; / the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	-				f. Location (St City or Town		Vumber or Au	ural Route Number,
_	To the Hospital or A within 24 hours after To the Funerel Direst completely filled in by	Medical Co	29a. Certifier 1 Certifying Physical Check only one)	sicien: To the best of my later: On the basis of exame and manner stated.	knowledge, deat ination and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, an th occurred	d due to the call at the time, d	ause(s) ar ate and pl	nd manner as ace, and due	stated. to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier				. License			1	9d. Date s	signed (Mont	h, Day, Year)
			Carl Mus C.				1/0	0560	5)		71	7/0	7
,	19		30. Name and address of person who co	mpleted cause of death (	Item 23a) (Type,	Print)		1	s) Hosx				·
1	1		Arvind Narasin	ham MD.	FROAT	War	4124	tur	HUSX	ita)			
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature		)						
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ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

Thomas Eugene Ruff State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day July 9, 2007 Medical Examiner 2036 hrs THOMAS EUGENE RUFF 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year Director Months Days Hours 215-68-3818 1X M 2 36 02/28/1971 Country) MD Usual Residence of Decedent RIIJ 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. MD CARROLL WESTMINSTER 1 X Yes 2 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 317 ROYER RD. 21158 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes after Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: WHITE "natural", 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should be filed within 72 hours 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ narked other than " Baltimore, MD 21215-0036 Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other transment 12 TEACHER EDUCATION 5 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be HENRY FENZEL RUFF PATRICIA TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 ROYER RD., JESSICA L. RUFF WIFE WESTMINSTER, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 7/14/07 Burial 2 X Cremation 3 Removal from State SOUTH CARROLL CREMATORY Donation 5 Other Specify: WINFIELD, MD 22 Name and Address of Facility FLETCHER FUNERAL HOME, P.A. Service Licensee WESTMINSTER. MAIN 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line Between Onset and /Medical Cardiac tamponade Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Ruptured acute aortic dissection Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED ending physician use as the burial <u> 27. perME.g869, 7/13/07 TI</u> The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown icate has been signed by the page 2 should be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 🗸 Unknown Completed Division of Vital Records. 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? certificate ✔ Yes 2 1 🗸 Yes 2 No he Hospital or Attending Physiciau: Thin 24 hours after death.
he Funeral Director: After this certifica pletely filled in by the funeral director, pa 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 ✓ Yes 27. Manner of Death 28a. Date of Injury (Month, Day,Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 X Natural Pending Yes 2 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4 determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ça To the 1 within 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatur 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. July 10, 2007 30. The and address of person who comp tuse of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 , Year) 31. Date filed (Month) JUL State Registrar

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

0	1- For State Registrar	Certificate of Death	Reg. No.	.200
Physician/ Medical Examine		chardson	2. Date of Death Month Day July 10, 2007  3. Time of 0225 i	
<u></u>	4a. Facility Name (if not institution, give street and number) 307 S. Fulton Ave.	4b. City, Town, or Location of Dea Baltimore	4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In y 217–33 – 25F4 1 M 2 F	rrs. last birthday) If Under 1 Year If Under 24H Months Days Hours Mi	<b>→</b>	
the Maryland a or 28a-f show any tified at once. Director	10a. State 10b. County 10c. (	City, Town or Location  Bathmore  10f. Zip Code	10d. Inside 1 Yes	e City Limits
ith the Ma 23a or 28 notified a		21223	· USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerlo  1 Yes 2 No specify:	o Rican, etc.) White, etc. Specify: Black	Black,
5-0036 led within 72 hour Hygiene. I other than "natin the Medical Exan	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College (1-4 or 5+)	d) 16a. Decedent's Usual Dccupation (Give kind of during most of working life. DD NDT use re	work done 16b. Kind of Business/Industry tired)	
21215-00 uid be filed wit Mental Hygien marked other tevent, the Mi	William Richardson	18. Mother's Nam	e (First, Middle, Maiden Surname)	
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than her traumatic event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print) Ginger Brown - mother	19b. Mailing Address (Street and Number or 367 St. Futton Ave	Rural Route Number, City or Town, State, Zip Code) Battimore Maylard	1223
more Pages 1 nent of Faut: If i	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	0b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory	Date 20c. Location - City or Town, State 7/14/07 Catonsville Man	iland
Balti permit. Departir Importi	21. Signature of Funeral Service License	22. Name and Address of Facility A 3512 Frederick Av	Ker Fureral Home, P.A. E. Battimore, Maryland	11229
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Sharp Force or condition resulting in death)	e Injuries	Between	nate Interval Onset and leath
niner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause	ce of):		
ecuted and - transit al Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence d.	ce of):		
ial lal	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of p			
D. Box 68760, the death certificate by the attending physic ched for use as the burner Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of p 1 Live birth 4 Pregnant at time o 9 Unknown	2 Fetal death 3 Ectopic pregr	ancy Month Day	Year
ires that the de signed by the signed by the the detached for the detached for the signed by Physical by Physical signed by Physical signed signed for the signed s	Part II. Other significant conditions contributing to death but n	oot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of	
cords law requestable been seen considered and			24a. Was an autopsy performed? 24b. Were autopsy finding prior to completion o death?	gs available
E	25. Was case referred to medical examiner?  1	26.Place of Death (Check ER/Outpatient 3 DOA Other Nurs	only one)	
Division of Vital Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certified filled in by the funeral director, al Certification: To Be (	1 Ves 2 No Inpatient 2  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation  1 Ves 2 No Inpatient 2  28a. Date of Injury FOUND: 5 UND: Jul 10, 2007	28b. Time of Injury FOUND: 0223 hrs  28b. Time of Injury 1 28c. Injury at Work? 1 Yes 2 ✓ No	ng Home 5 Residence 6 ✔ Other: Scene  28d. Describe how injury occurred  Subject stabbed and cut	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune- ledical Certification:		At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route No or Town, State) 307 S. Fulton Ave., Baltimore, Md.	ımber, City
To the Hospital within 24 hours. To the Funeral completely filled Medical Cert		vledge, death occurred at the time, date and place, an on and/or investigation, in my opinion, death occurred		
Me T x	298 Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year July 10, 2007	ir)
3	30. Name and address of person who completed cause of death (i Laron Locke MD. Assistant Medical Examine	er 111 Penn Street, Baltimore, MD 212	201	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Sign	the Course		
DHMH 17 Rev 1/2001	OCME	ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh g869 7-16-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Spencer 9:25 PM 10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORI (000) SAMA RIPAN HOSO17M-NA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 218-12-0869 83 3-18-1924 N.Y. Usual Residence of Deceden death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County rai", or items 23a or 28a-f show Examiner must be notified at Yes 2 No Directo Md. NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1401 N. Lakewood Ave Apt 325 21213 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Itel any Injury or other traumatic event, the Me ix al Examiner 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Cook Various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert 2 Unkn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Brown Godson 2713 Gresham Way , Windsor Mill, Md. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Baltimore Natl. Cem Garrison Forest Vet 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto. 7-16-07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Bry Wille 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMPH IA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 FAILURE 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? e Hospital or Attending Pl 24 hours after death. e Funeral Director; After ti 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of derafier ATTONDING 29d. Date signed (Month, Day, Year) DR MAN N. 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMARITAN HOSPITAL 6000 31. Date filed (Month Day, 32. Registrar's Signature

Registrar

Physician
/Medical
Examiner
LAGIIIIIei

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	For State Registrar			aryiano		artment of H rtificate of L			Reg. N	711	67	22	391
an	1. Decedent's Name (F							2. Date of De Month	D	ay	Year	3. Time of	
al	Ellen Car					4b. City, Town, or	Location of Death	July 5,		c. County of	of Death	8:10	PW
er	Shady Grov	. 5	ŕ	tal		Rockvill				ontgo			
	5. Social Security Number	ber 6. Se	ex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th			place (State o	r Foreign
	297-56-354	5	□M 2 <b>X</b> F	53	Yrs.	Months Days	Hours Min.	July 5	, 19		Penn	isy1van	ia
	Usual Residence of De- 10a. State 10	cedent b. County		10c. City.	Town or Lo	ocation						10d. Inside Cit	v Limits
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rect	Maryland 10e. Street and Numbe	Montgom	ery	Poto	mac	10f. Zip Code			10g. C	itizen of W	/hat Cou	intry?	
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nera	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spanic Origin?	pecify Yes or No	-			ican Indian,	
Be Completed by Funeral Director	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	No		1 Tes, specify Cuba 1 ☐ Yes 2 No	Specify:			k, White, Wh:			
eted		. Decedent's Ed			16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	king	16b.	Kind of Bu	siness/Ir	ndustry	
mpl	Elementary/Seconda		College (1-4or 5	+)	`life.		)			T 077			
S	17. Father's Name (Firs	st Middle Last)	5+			Attorney	18. Mother's Nan	ne (First, Middle		Law en Surnami	e)		
Be	Irving Se						Beverly			ar ournam	0)		
ို	19a. Informant's Name		vpe. Print)		19b. Mailir	ng Address (Street a				or Town, a	State, Zi	ip Code)	
	Bruce Pea		(Spouse)		9425	Copenhave	er Dr., E	Potomac,	MD	2085	54	,	
	20a. Method of Disposi	ition		20b. Pla		osition (Name of matory or other place		Date				own, State	
	1 M Burial 2 L C 4 L Doynamen 5 [		Removal from State  ')			e Cemetery		<b>'</b> 07	So	lon,	OH		
8	21. Sign fure of uner	ral Service Lic	ee)		2: H	2. Name and Addres Berkowitz- 1985 Soutl	ss of Facility -Kumin-Bo n Taylor	okatz M	emo	rial land	Char	pel 4	4118 H
	23a. Part1. Enter the o	disease, or comp	plications that caused	the death.								Approximate Interval Bet	9
9 6	Immediate Cause (Final disease or condition		Respira								Ţ	Onset and I	Death
	resulting in death)  Due to (or as a consequence of):												
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ine	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ediate			onsequence of):								
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edic			.0.										
Be Completed by Physician/M	IF FEMALE: 23b. Was decedent proin the past 12 mo 1 ☐ Yes 2 ☒ N 9 ☐ Unknown	onths?	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal o	leath 3	⊒Ectopic pregnancy ⊒ Other <i>(sp</i> ec <i>ify)</i>				23d. Date Mor			⁄ear
y P	Part II. Other significa	int conditions c	ontributing to death b	ut not result	ing in the u	ınderlying cause giv	en in Part I.	23e. Did 1	obacco	use contr	ibute to	the cause of d	eath?
ed b	Cecal Volv	ulus wi	th Perfora	ation		<u> </u>		1 🗆	Yes	2 <b>X</b> No	3 ☐ Pro	obably 4 □L	Jnknown
<b>amplet</b>								24a. Was auto perfo 1 Yes	psv	l p	rior to co leath?	topsy findings a	available ause of
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To B	examiner? 1 ☐ Yes 2 <b>ॉ</b> No		Hospital: 1 X Inpatie	nt 2 E	R/Outpatie	nt 3 DOA Oth	or.	lome 5□Resi	,	6 □Othe	er (Spec	rify)	
nc:	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	of 28c. Injur World	y at </th <th>28d. Describe</th> <th>how inj</th> <th>ury occurr</th> <th>ed</th> <th></th> <th></th>	28d. Describe	how inj	ury occurr	ed		
catio	2 Accident	investigation			-		Yes 2 □ No						
rtifi	4 ☐ Homicide	determined	28e. Place of injuding, et	ury - At hom c. <i>(Specify)</i>	ie, farm, st	reet, factory, office		28f. Location ( City or To	Street a wп, Sta	and Numbe ite)	er or Rui	ral Route Num	ber,
ٽ ا	29a. Certifier 1	*Certifying Ph	ysician: To the best	of my know	ledge, deat	th occurred at the tir	ne, date and place	e, and due to the	cause	(s) and ma	inner as	stated.	
Medical Certification:			niner: On the basis o and manner st	f examination									)
Me	29b. Signature and title	e of certifier	)	_		29c. License	e number		29d. D	ate signed	(Month	, Day, Year)	
	> Yosh	h A B	#11 MD			D5331	7		7	· ly	6	2007	
	30. Name and address  Joseph A			eath (Item 2	reder	ick Rd #	213 Gait	nersburg	g, M	ID 208	377		
te	31. Date filed (Month,	Day Voor	22 Dogietr			parle							
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Sta Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July **Physician** Caroline Μ. Strong ďĝ 2007 2:30 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 28 Stoneridge Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Jan 23, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1944 1 □ M 2 X F North Carolina 63 259-84-3644 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural" ~ ... any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Baltimore Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21239 28 Stoneridge Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify. White Specify: þ 3 ☐ Widowed 🏄 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Life Line Coordinator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stevens Mary Miller Arthur ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Stoneridge Ct. Baltimore, Md. 21239 Mr. Bryan Strong/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7-11-07 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 21. Signature of Fymera, Service Licen Racknotowsoharmuneral Home, 1050 York Rd. Towson, Md. 23a. Part1 Enter the diseale, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** one month disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ☐ Unknow# 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1∐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) × No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA P 1 🔲 Yes 1 Inpatient Manner of De 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral [

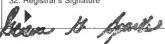
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

D0056239

who completed cause of death (Item 23a) (Type, Print) Name and address of per#

200 Veronica 32. Registrar's Signature 31. Date filed (Month, Day, Year)



State Registrar

		1_ For State	State	of Maryla			Health and	-	6	047	22395	
		1 - Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)							Reg. No.  2. Date of Death  3. Time of Death			
Physicia					cm	ביז דביואזכי		Month JULY	Day	Year 2007		
/Med Exam		4a. Facility Name (If not institution, give street and number)				EVENS 4b. City, Town,	or Location of Deat		LY 10, 2007 8:45 A  4c. County of Death		0:43 A	
LAGIII	11161	FOREST HILL HE	NTER	FO	REST HILI			HARFORD				
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs.			. last birthday)	If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.		8. Date of Bir	th v Year)	9. Birthplace (State or Fo		
Directo	r	216-30-9299	1 <b>X</b> M 2 ☐ F	72	2 Yrs.	Wolling Days	710015 (VIII).	July 2	4, 1934	Sout	h Carolina	
and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits	
Manyl f sho ied al	0	Maryland Harford Edgewood 1 □ Yes 2\S No										
the 28a-	Director	10e. Street and Number 10f. Zip Code							10g. Citizen of	What Cou	ntry?	
h with		303 Bauers Drive				21040			USA			
deat	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	U.S. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	- 14. Ra	ce - Ameri		
after or it		1 □ Never Married 2 【XMarried 1 □ Yes 2 X No				☐Yes 2€ No			Specify:			
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uld be Wenta Wenta urked urked	일	Preston McManus Stevens Minnie Lee Tho							Thompso:	ompson		
and and is ma		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailin	g Address (Stree	et and Number or R	ural Route Numb	er, City or Towr	n, State, Zij	Code)	
c, IN i and Health im 27 ther to		Carolyn L. Ste	vens / Wi	fe	303 ]	Bauers D	rive, Edg	gewood, I	Marylan 20c. Location			
or of each		1 Burial 2 Cremation		Ctoto	cemetery, cren	natory or other pl	corp. 7–1					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone.	al al	4 ☐ Donation 5 ☐ Other (S		17.	- 1			- '	Towson	, Mai	yrand ————————————————————————————————————	
Depail Important		McComas Funeral Home, P.A.										
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									Approximate Interval Between	
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tificating phy as the	ledi		- W.									
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e dea the at	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)		·	Month Day Year					
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ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	☐ ER/Outpatien	t 3 DOA	thor:	Home 5□ Resi		ther (Speci	fy)	
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tendii eath. tor: A	catic	2 Accident investigation				M 1 ☐ Yes 2 ☐ No			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
or At affer d Direct	Certification:	4 Homicide determ	e of injury - At h ding, etc. <i>(Spec</i>	of injury - At home, farm, street, factory, office g, etc. (Specify)								
spital ours a		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To ti withii To ti	M	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)										
1		1 DNU 19583 July 10 20									007	
5 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MANUEL LAZATIN - 8 LAW STREET - ABERDEEN, MD. 21001										
<i>y</i>	tate	MANUEL LAZATIN  31. Date filed (Month, Day, Year)	. 32.	Registrar's Sign	nature	BERDEEN	, MD. 21	001				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mary Charlotte Smith 10:25 PM 2007 Julv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 XX F 213-32-9640 Director 76 October 4,1930 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified Maryland n/a Baltimore Director 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 124 W. Franklin St. 21201 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bonce. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 housekeeper MD School for the Blind 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Ingram Elizabeth Smith ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Yellowwood Ave., Apt. 717 Linda Smith/daughter Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery July 11,2007 Parkville, Maryland 22. Name and Address of Facility edefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, lay leaving terminolate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has autopsy
performed

1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 1 🗀 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Hospice St Baltimore MD 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL

		For State	State of Mary	land /	•	nt of Healt te of Dea			L. u		22393
		Registrar  1. Decedent's Name (First, Middle, I	ast)		Ooranoo	ite or bea		2. Date of Dea	th		3. Time of Death
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of Heelin and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-1 show other traumatic event, it's Medical Examinar must be notified at To Bo Compiled by Eupared Directors		10a. State 10b. County	100	c. City, Tov	vn or Location					1	Od. Inside City Limits
Part of S	20	West Virginia	Monongalia			Morgant	own				1√2 Yes 2 □ No
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in teme 23e or 28a-f eliner must be notified	2	213 C. Morgan				265			J.S.A		
me di		11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Dec	edent of Hispanio ecify Cuban, Mex	c Origin? (Spe kican, Puerto f	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
io.	Dy L	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2♥ No If Yes, Give Year or Dates:		1 ☐ Yes	No Spe	city:		Sp	<sup>ec/</sup> ₩hite	۵
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T T	-	19a. Informant's Name/Relationship	_	19	b. Mailing Addre	ss (Street and Nu	imber or Rura.	/ Route Numbe	r, City or To	um, State, Zip	<sup>Code)</sup> 26508
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othe	-	Michael Shaw 20a. Method of Disposition	// Son	Ob. Place	of Disposition (A	ame of	AH-FO	ate	20c. Locati	ion - City or To	estVirgir own, State
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	20 0	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		h 3 ⊟Ectopic 5 ⊟ Other (				200	Month	Day Year
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signed b		Part II. Other significant conditions	contributing to death but no	t resulting	in the underlying	cause given in P	art I.	23e. Did to	bacco use	contribute to th	ne cause of death?
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should								24a. Was a	2	Ab Ware auto	ney findings available
99 2	<u> </u>							autop	sy med?	prior to cor death?	psy findings available mpletion of cause of
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irector, page 2 s	٥.	25. Was case referred to medical examiner?	Hospital:			Other		(Check only or			
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To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	5	Natural 5 Pending	(Month, Day Yea	ar) 200.	Injury	28c. Injury at Work? 1 ☐ Yes		ou. Describe II	ow injury or	ccurred	
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B 2		29a. Certifier 1X Certifying	Physician: To the best of my	v knovdoda	o doath assured		a and place of				
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ompletely fill	Me	29b. Signature and title of certifier	and manifel stated.		1 2	9c. License numi	Der	- :	9d. Date si	igned (Month,	Day, Year)
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			medic	all	10ctor	RES-	000		JUNK	20	2007
>		30. Name and addr s of person when De Let no Tree Ji 31. Date filed (Month, Day, Year)	o completed cause of death	(Item 23a)	(Type, Print)	and a second	0.000			2	4 0.305
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State	•	31. Date filled (Month, Day, Year)	32. Hagistrar's	aigi iature	Karek	T 10				,	

amend 1 per Dr. g869 7/12/07 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mar		artment of rtificate o		Mental Hygier	C. U. C.	22399	
	Physica /Media		1. Decedent's Name (First, Middle, Last	Baby Girl	Spain-Vi	nson	_	2. Date of Death Month  February	Day Year	3. Time of Death 2335 PM	
	Examir	er	4a. Facility Name (If not institution, give Sina Hospital  5. Social Security Number  6. Se	of Bultin	nore (In yrs. last birthday)	4b. City, Town  Bultin  If Under 1 Yes		th /	4c. County of Death	A lace (State or Foreign	
l.	Funeral Director			ÎM 20 €	O Yrs.	Months Day	rs Hours Min	. (Month, Day, Yea	ear) Country)		
	death with the Maryland ms 23a or 28a-f ehow final to notified at	ctor	10a. State 10b. County Maryland Baltin		Oc. City, Town or Lo				10d. Inside City Limits 1 □ Yes 2 1 No		
	death with the Maryla ims 23a or 28a-f e-hov	Funeral Director	10e. Street and Number 8325 Township	Drive		10f. Zip Code	)	10g. (	Citizen of What Cour	itry?	
9036	hours after dea tural', or Items	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces?  1  Yes 2 D No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Co	f Hispanic Origin? (Suban, Mexican, Puel ob Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Black	etc.	
21215-0036	in 72 in mai	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of wo ired)	nrking 16b.	Kind of Business/Ind	dustry	
Maryland	2 should be filed with and Mental Hygiene. Is marked other than raumatic event, the M	To Be C	17. Father's Name (First, Middle, Last)	UINS			JEann	me (First, Middle, Maid & Spain-	-Vinsor		
	is 1 and 2 should of Heelth and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (T) Sinai Hospita	1	24016	U. BELVE		ural Route Number, City	nort, mo	L Z1215	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite eny injury or ot once.		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Hosp, A	20b. Place of Dispo cemetery, cren Sinai /		TXL 4/		Location - City or To		
Ball	Departition Depart		21. Signature of Funeral Service Licens	Wach	22	Name and Add	Belvene	RE AVE. K	BACTIMOR	Md NUTHORE LHD ZIZIS	
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate	Due to (or as a c	e death. Do not ent  Cardia  consequence of):  The pre	er the mode of d	ying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Interval Between I	
8760,	ate be executed hysician and the burial-transit	dical Examine	Cause (Disease or injury	Due to (or as a c							
P.O. Box 6	the death certific y the attending p ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	I3c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnar Other (specify)		-	23d. Date of delive Month	ry Day Year	
	w requires that been signed b should be deta	۵	Part II. Other significant conditions con	ntributing to death but r	not resulting in the ur	nderlying cause o	given in Part I.		o use contribute to the		
of Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy performed?	death?	osy findings available inpletion of cause of	
Z:		Be	25. Was case referred to medical examiner?	fospital:		_ [c	Note	ath  Check only one			
on of	aling Phys	lon; To	27. Manner of Death  1 Natural 5 □ Pending	28a. ate of Injury (Month, Day Y	2 ☐ ER/Outpatien 28b. Time of Injury	28c. in	ury at ork?	lome 5 Residence		)	
-	To the Hospital or Attending Phywithin 24 hours alter death. To the Funeral Director: After the Completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, stre Specify)		□Yes 2□No e	28f. Location (Street City or Town, Sta	and Number or Rura ite)	Route Number,	
	To the Hospital of within 24 hours at To the Funeral D or mpletely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or inv	noncurried at the restigation, in my	time, data and plane opinion, death occu	and due to the causa urred at the time, date a	e) and manner as st nd place, and due to	the cause(s)	
	To th C mp	Me	29b. Signature and title of certifier	hitna	h m	/ <b>\</b>	37630		Pate signed (Month, I		
V. (	S.#	- 1	30. Name and address of person who co	empleted cause of deat	h (Item 23a) (Type, I	Print)	A	Feb	roury	7, 2007	
	Sta Registr	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Were	HVE 1	baltimeri	e, mol 1	13/5	

Spain-Vinson

Day

Physician
/Medical
Examiner

1 - For State Registrar

**BEVERLY** 

· ·	/Medi		BEVERLY					SHAI	RESTEI	N	JULY	10	2007	12.43 P
A SEC	Examir	er			give street and number	•		4b. City, Tow	n, or Location	on of Death		4c. C	ounty of Dea	th TE-FO
		-	5. Social Security		CE-HEALTH	CENTE! Age (In yrs. la			IMORE	der 24 Hrs.	9 Date of B	irth	0.0	N/A
	Funeral Director		125-22- Usual Residence	4661	1□ M 2 <b>X</b> F	<b>87</b>	Yrs.		ays Hour		8. Date of B (Month, D 02/25	/1920	9. Bir	thplace (State or Foreign ountry) NY
/land	ow		10a. State	10b. County		10c. City	, Town or L	ocation						10d. Inside City Limits
he Man	r 28a-f show notified at	Funeral Director	MD	N/A	1		BALTI					T		1X Yes 2 □ No
with t	a or	Di.	10e. Street and N		DEET ADT	#00r		10f. Zip Coo				Tog. Citize	n of What Co	•
leath	ns 23 musi	era	11. Marital Status	401n 3	TREET, APT	nt Ever in U.S	S. 13	. Was Decedent If Yes, specify	21211 of Hispanic	Origin? (Spe	ecify Yes or N	lo- 14	USA . Race - Ame	
215-0036 thin 72 hours after death with the Maryland	natural", or items 23a or dicai Examiner must be	þ	1 Never Ma	rried 2 Marrie	Armed Force	s? No		If Yes, specify of 1 ☐ Yes 2 🚺			Rićan, etc.)		Black, Whit	•
2 2	"natu edica	lete	(Spi	15. Decedent's ecify only highest	Education grade completed)		(Giv	edent's Usual Oc e kind of work do DO NOT use re	one during m	nost of work	ing	16b. Kind	of Business	Industry
2121	r Health and Mental Hygiene. Item 27 is marked other than "natul other traumatic event, the Medical	Completed	Elementary/Sec	condary (0-12)	College (1-4d	or 5+)	me.	HOMEM	,				OWN HO	ME
	d other	BeC	17. Father's Name	e (First, Middle, La	ast)				18. Mo	other's Name	(First, Middl	e, Maiden St	urname)	
yia ould b	Ment arkec atic e	2	HENRY				Z	EVIE	FA	N				SLOAT
Maryland	h and 7 is ma frauma			Name/Relationship				ling Address (St.						
	If Health Item 27 other tr	. 3	20a. Method of Di		IN / SON	20b. PI	ace of Disp	AST BISI	f		DALIIM Date	~	tion - City or	
	O		1 ☐ Burial 2		B □Removal from Sta ecify)	te HIL	t <b>TOP</b>	ematory or other SERVICE	CORP.	07/1	1/2007	1	ON, MD	
Balti sermit.	Department important: I any Injury o		21. Signature of F	uneral Service Li		,	1	22. Name and A	ddress of Fa	cility SOI	L LEVII	NSON &	BROS.	, INC.
	O 01 = 10				omplications that caus	and the death							VILLE,	MD 21208 Approximate
	and a		shock, or he	art failure. List o	nly one cause on each	line.					14			Interval Between Onset and Death
S	ysician Medical		disease or condit resulting in death	on	a. Juer y	as a consequ	ence of:	ve to an	Noin	man	e rep	arth	2	Years.
Exa	aminer					ao a consequ	01100 017.							
70	sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
ecuter	transi	Examiner	Cause (Disease of that initiated even resulting in death)	ts	с									
50, Se exe	cian a ourial-	Ě	resulting in death,	Last	Due to (or a	as a consequ	ence of);							
.O. Box 68760, the death certificate be executed	been signed by the attending physician and should be detached for use as the burial-transit	nysician/Medical			d									
OX 6	nding Ise at	/Me	IF FEMALE: 23b. Was decede	nt prognant	23c. If yes, outcon	ne pf pregnar	псу	_				230	d. Date of de	ivery
. <b>B</b>	d for	iciai	in the past 1	2 months?	1 □Live birth 4□Pregnant	at time of de		□Ectopic pregn □ Other <i>(specif</i> )					Month	Day Year
	by the		9 ☐ Unknow		9□Unknown									
	igned be de	by P	Part II. Other sign	Ificant condition	s contributing to death	but not resul	Iting in the	_1		rt I.				the cause of death?
or Vital Records, Physician: The law requires t	een s	ted	gas	aco-in	testinal	ace	sun	y aue	80		1	Yes 2	No 3□Pi	obably 4 Unknown
Sec e law	has e 2	Completed	Con	pelopa	Thy						24a. Wa aut	opsy	_ prior to	itopsy findings available completion of cause of
	ate		0	, .	7						1□ Yes		death? 1 ☐ Yes	2 🗆 No
Vision or Vita	his certifica I director, I	Be	25. Was case reference examiner? 1 ☐ Yes 2 №	No medical	Hospital:	tiont OFF	D/Oute etie	ent 3 DOA	Othor		(Check only			
O Phy	n. After this funeral d	2	27. Manne of Dea		1 ☐ Inpa	njury	28b. Time		Injury at Work?		me 5 Res 28d. Describe			cify)
ion in the factor of the facto	r: Aft	atio	<ol> <li>Natural</li> <li>Accident</li> </ol>	5 ☐ Pending investiga		Day Year)	Injury		work? 1 ☐ Yes 2	□No				
Division i or Attending	recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ad   Zoe. Flace of I	njury - At hor etc. (Specify	ne, farm, s	treet, factory, off	ice	:	28f. Location	(Street and I	Number or Ri	ural Route Number,
Ditai o	rrs arr ral Di			_/_										
e Hosp	within 24 hours after deam.  To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one)	1 M CertifyIng 2 Medical E	Physician: To the best caminer: On the basis and manner	of examinati	vledge, dea ion and/or i	th occurred at the nvestigation, in the	ne time, date my opinion, o	and place, death occurr	and due to the red at the time	e cause(s) ai e, date and p	nd manner as lace, and due	stated. to the cause(s)
To the	To th comp	Me	29b. Signature an	d title of certifier				29c. Lic	ense numbe	er		29d. Date s	signed (Mont	h, Day, Year)
	-		DIT By	Thele V	The gre	982	TID	D	1365	7		July	10,2	207
11	1	Ī	30. Name and add	iress of person w	ho completed cause of	death (Item	23a) (Type	Print) FO H S	24	A.	1.1.	The state of the s	2 3	
10			31. Date filed (Mo	OTH Day Year)	984RBGOR	yar's Signati	W. L	to The S	need	sae	fuco le	, V/CE	NZI	1
	Sta Registr	-	or. Date fried (MO	!!!! 1	2007	July Solynan	19	Areal !	,					
DUMU 1	17 Rev 1/20		-	JULI	C LOUI P	A STATE OF THE STA	10.	The same of the sa				· ·		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11 2007 12:45 p<sup>M</sup> Thomas-Hyman Ju1vΜ. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7 Francine Court Randallstown Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) MAY 21 1950 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 X F 213-58-3065 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Baltimore Randallstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 7 Francine Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**▼** No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First Middle Last) æ permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evo Thomas Mary Leo Henry Louise Queenan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine Court, Randallstown, MD Sheldon M. Hyman - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 7/12/2007 | Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, Inc. HWW 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician curuna years OVERNO /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran and Due to (or as a consequence of): Box 68760, nding physician the death certificate be Physician/Medical the ! as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death the Funeral Director: npletely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) Other MD D40850 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmane 21237 OTTAV, AND MD 9103 Franklin Spune Dr. MD VINNE 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 12 Registrar

				_ For	State of M	aryland / De	epartment of I	Health and	Mental Hyg	giene 007	22402	
				1 - State Registrar Amend 19b, pe		/12/0/ 11 (	zertincate or	Dealii	2. Date of Dea	Reg. No.	3. Time of Death	
		Physici	an						Month	Day Year		
		/Medic	cal	Margaret B. Tyl		1	4h City Town	or Location of Deat	July 6	4c. County of Death	12:10 a <sup>M</sup>	
		Examir	ner		e street and number)	,	Cockeys		••	Baltimor		
				Broadmead  5. Social Security Number 6. S	Sex 7. Ac	ge (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs			place (State or Foreign intry)	
	ш	Funeral Director			□м ¾□F	91 Y	Months Davs	Hours Min.	March	29 1916 MD		
	C.			Usual Residence of Decedent					1101	7		
		nylan how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 No	
_		e Ma	çç	MD Baltimo	ore		Cockeysvil	le				
7		ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	intry?	
7:10 am		, 72 hours after death with the Maryland "naturel", or Items 23a or 28e-f show tubbell Examinet much be notified at		13801 York Rd.				21030	N	USA 14. Race - Amer	ioan Indian	
1		er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Black, White		
d	36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 [X] If Yes, Give Year or Dates:	No	1 ☐ Yes 2 💆 No	Specify:		Specify: whi	te	
~	21215-0036	72 hours after naturel', or ite	ed t	15. Decedent's E		16a. C	ecedent's Usual Occu	pation		16b. Kind of Business/l	ndustry	
	15	in 72 n • ne	piet	(Specify only highest gra	ade completed)		Give kind of work done ife. DO NOT use retire	e during most of wo ed)	rking			
	212	iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or		eacher			Education_		
1	b	Hyg Hyg othe	BeC	17. Father's Name (First, Middle, Last	)	18. Mother's Na	me (First, Middle,	Maiden Sumame)				
0	a	Ald be Alenta Treed Tices	To B	Jesse Wilmer Bowe	en			Marga	ret Elle	n Taylor		
R	Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Menial Hygiene.  If Item 27 is marked other than "naturel", or Items 23s or 28e-f show or other traumatic event, Ite Marical Examiner ninth by notified at	Γ.	19a. Informant's Name/Relationship (	Type, Print)	195.7	Aailing Address (Stree	t and Number or Ri	ural Route Numbe	r, City or Town, State, Z <b>Y</b> 4	ip Code)	
1	Σ	and 2 paith a		Bruce Hornung, ne	ephew	12.	ib Angler	Kd., Uce	an Ulty,	TH 21042		
3	ore	of He		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from State	20b. Place of D	Disposition (Name of crematory or other pla		Date	20c. Location - City or Town, State		
0	Ĕ	Pag ment ant: I		* 4 □ Donation 5 □ Other (Special	(y)	Metro (	Crematory	7/	9/07	Catonsville	, MD	
1,	Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mennal Hygiene. Important: If Item 27 is marked other than "eny injury or other traumatic event, Itia Mas. 2005.	(	21. Signature of Funaral Movice)  LOWe 11 M. Len	mon		Lemmon Fur	ess of Facility neral Hom	e of Dul	aney Valley m, MD 21093	, Inc.	
				23a. Part1. Enter the disease, or com shock, or heart failure. List only		d the death. Do no	t enter the mode of dy	ing, such as cardia	c or respiratory ar	rest,	Approximate Interval Between	
		Physician		Immediate Cause (Final	M/	In & bal	200	mon	-		Onset and Death	
	7	/Medical		disease or condition resulting in death)	Due to (or as	s a consequence of	):	naj				
	*	Examiner		0 10 11 15-1 100	b							
		P. =	ner	Sequentially list conditions, if any, leading to immediate cass. Linter Unionlying Cause (Disease or injury	Due to (or as	s a consequence of	):					
-		be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
1)	760,	e be execu sician and e burial-tra		resulting in death) Last	Due to (or as	s a consequence of	<b>)</b> :					
R	6876	certificate be execuivding physician and use as the burial-trai	licai		d							
2		entific ding F	Physician/Medi	IF FEMALE:	23c. If yes, outcome	a of pragnancy				23d. Date of deli	-	
	Вох	death c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		Month	Day Year	
T	0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of death	5 ☐ Other (specify)					
5	9	requires that the death certificate een signed by the attending phys hould be detached tor use as the		Part II. Other significant conditions	contributing to death i	but not resulting in t	he underlying cause g	iven in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
_	ds,	w requires that been signed I should be det	d by	humacal	comia	2			1 🗆 Y	es 2 ⊞No 3 ⊟ Pro	bably 4 \(\begin{array}{c}\)Unknown	
De	Record		Completed						24a. Was :	an 24h Were au	opsy findings available	
0	ě	42 00 00	d L						autop perfor	med? prior to death?	ompletion of cause of	
1	all	ician: The lav certiticate has rector, page 2		ac in a second contact of				Pi (	1 ☐ Yes		2 □ No	
>	Vital	Physician: r this certific ral director.	o Be	25. Was case referred to medical examiner?	Hospital:	ient 2 ☐ ER/Outp	SCI DOA OI	than	ath (Check only o	<i>ne)</i> lence 6 □Other ( <i>Spec</i>		
1-	o	Phys r this rai dir	Η.	1 Yes 2 No	28a. Date of Inj	ury 28b. Tir	ne of 28c. Inju	ury at		ow injury occurred	ny)	
j		ding F h. Atter funer	tlon	1 D atural 5 Pending 2 Accident investigation	(Month, Da	ay Year) Inj	ury Wo	ork? ]Yes 2.∏No				
	vision	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not b	28e. Place of In	jury - At home, fam	n, street, factory, office	)		Street and Number or Ru	ral Route Number,	
	ģ	alor A satter I Direct din by	Certification:	4  Homicide	building, e	tc. (Specify)			City or Tow	ni, state)		
(10		To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: Atter this certificate his completely tilled in by the funeral director, page	edical C	(Check only 2 Medical Exa	miner: On the basis of	of examination and/				cause(s) and manner as date and place, and due		
•		To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner s	1	29c. Licen	nse number	1	29d. Date signed (Month	, Day, Year)	
		F 3 F 8		Bantona	(1111	Ul VI	X) D	3839	72	7/6/	2007	
		-V		30. Name and address of person who	completed cause of	death (Item 23a) (T	ype, Print)			, , , ,	/	
	0	1		BARBARA CA	RROW	M.D.	13801	VORK	RD.	COCKEY	SVILLE, MI	
	Í	Sta	ate	31. Date filed (Month, Day, Year)	2007 32. Regist	rar's Signature	Sparte	-				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Mary Sharp 1:05 ( M Tawney 9 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Hospital Baltimore If Under 1 Year Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M XXF 173-22-7033 85 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b, County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2☐No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 6001 Hunt Ridge Road 21210 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Ite any Injury or other traumatic event, the M-di-al Examine. 1 ☐ Never Married 2 ☐ Married Maryland 212/15-0036 1 ☐ Yes 2 XXNo Specify: White Specify: XXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sharp Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C Lee Tawney 233 West Lanvale Street Baltimore, Maryland 21217 Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2XX Cremation 3 ☐ Removal from State Green Mount Crematory 7/10/07 □Donation 5 □ Other (Specify) Baltimore, Maryland nature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) arre /Medical Examiner 2011/c Aneurysm if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) detached the 9□Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 4 Nnknown Abdominal Austic aneurySm 1 ☐ Yes 2 ☐ No 3 ☐ Probably peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No has page 2 autopsy perform certificate 2 🕽 Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifler

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral I To the Hospital

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Baltimore 2401 W. Belvedere

29d, Date signed (Month, Dav. Year)

15

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Bessie May VonGunten /Medical Ju<sub>1</sub>y 2007 10:50AM <sup>M</sup> 11, 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Long View Nursing Home Manchester Carroll 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 1 ☐ M 2 🗶 F Days Hours 99 Yrs Director 212-22-7256 April 4,1908 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified Director 1 ☐ Yes 2 ☑ No MD Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or ' ritems 23a o iner must be 2130 Old Westminster Road 21048 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Moser 2 Percilla Shorb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Oursler 16039 Trenton Road, Upperco, MD 21155 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gard 4 ☐ Donation 5 ☐ Other (Specify) 7/16/07 Finksburg, MD 21. Signature of Funera 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 23a. Part1. Enter in dis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-t Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician hed for use as the buria death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) ☐ Yes 2 1 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ NO 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performe this certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner\_of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours are: \_\_\_\_ To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 688 Poole 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ai yiai i		rtificate o			nemai i iy	Reg. N	0.0	1 /	22	5.0.5
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	Physicia /Medic		Marcelle Vandendr	iessche						July 9		007		12:05	P. M
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Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:		5.   13.	Was Decedent or If Yes, specify Cu 1 ☐ Yes 2 🖾 N			o Rican, etc.)	0-	Black, Specify:		etc.	
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ar	2 sho and is ma		19a. Informant's Name/Relationship				ng Address (Stre							Code)	
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Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	£	M0089	96 BC	2. Name and Add bert A. Pu O W. Moi	itgom	iery A	ve., Ro	ckv:	ville, I ille,	nc. MD	20850-	2805_
			23a. Part1. Enter the disease, or conshock, or heart ailure. List only	plications that caused one cause on each lin	the death	. Do not en	ter the mode of d	ying, such	h as cardiac	or respiratory	arrest,			Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition				Cardiova							Onset and D years	Jeam
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68760,	cate physi the	edical	•	d	-										
Vital Records, P.O. Box 6	eath cer attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	□Ectopic pregnal □ Other (specify)					23d. Date of Month		-	⁄ear
σ.	that ted by	, Ph	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the u	inderlying cause	given in P	art I.	23e. Did	tobacco	o use contribu	ute to t	he cause of d	eath?
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7	hysl this c	은	1 XYes 2 No	Hospital: 1 ☐ Inpatie			III DOY		Nursing H	ome 5 🖾 Res				fy)	
Division or	I or Attending Physician: The after death.  Director: After this certificate ha in by the funeral director, page	Certification:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	V	ork? ☐ Yes 2	2 □ No	28d. Describe	now in	jury occurred			
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	pital or ours afte eral Dii filled in														
	Hos Fun ely	Medical	29a. Certifier 1 ☒ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best miner: On the basis o and manner st	f examinat	wledge, dea tion and/or i	th occurred at the	time, dat y opinion,	te and place , death occu	r, and due to the	e, date a	and place, an	d due t	o the cause(s	·)
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	. 1/		/ Sexym X	rumi, 1	M. J	4		8381			Ju1	y 10,	200	7	
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	Sta Registr		31 Date filed (Month Day, Year)	32. Registr	ar's Signa										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 24a, 25 g869 Certifippe of Derth per Dr. Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** : 20A MARIE 22, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Maryland Medical Center In iversity of 8. Date of Birth (Month, Day, Year)
May 21, 20 If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 ☐ M 2 🛛 F May 2007 Maryland Director none Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number pe o 21217 1411 Division Street USA ral", or items 23a Examiner must b Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: black 3 ☐ Widowed 4 ☐ Divorced natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) none none nt of Health and Mental Hyg if item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk 2 Marie Bentley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) University of Md Hospital S. Greene Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if any Injury or 4 □ Donation 5 ₩Qther (Specify) in state Signature of Euneral Service Licensee Royald S. W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Syndrome Respiratory
Due to (dr as a consequence of) **Physician** 30 kms /Medical Examiner ematuri Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s performed' certificate 2 No Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28b. Time of 27. Manner of Death 1 Matural 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 □ No after death. 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of terson who completed cause of death (Item 23a) (Type, Print) 11de 22 3. Greene Street N5W68 Mobolalit Year) State

Registrar

Physician /Medical Examiner Funeral Director

pwrmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3:40 PMBruce Philip Wallace 7 9 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Glen Burnie Anne Arundel 1300 Aster Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 7-31-1956 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Months 1 X M 2 ☐ F 50 MD 216-70-4453 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No MD Director Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1300 Aster Drive 21061 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify white 3 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Logistics Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace Sr. Earle Grace ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Wanda E. Wallace/wife 1300 Aster Drive, Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/12/2007 Elkdridge, MD Meadowridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee M01364 1 Second Ave SW Glen Burnie MD 21061 First. Enter the law as, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each pre-Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as cou equence d Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1□ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1x Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month) Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation HUNG Self 1 ☐ Yes UNK 2 Accident 4 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Glew Butwee, m D 3 Suicide 4 Homicide to me 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s. ted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) JONES

State

Registrar

Date filed (Month, Day, Year)

JUL

32. Registrir's Signature

2007

		-		f Maryland / Depa	artment of Health and Natificate of Death	_	e 0 0 7	22406
			1. Decedent's Name (First, Middle, Last)	0/13/0/ 11 00/	timodio or Bodin	2. Date of Death	40.	3. Time of Death
	Physicia					Month I	Day Year	
	/Medic	al -	Loy L. Wood			July 9	2007 tc. County of Deatl	5:54 A.M
	Examin	er	4a. Fecility Name (If not institution, give street and number	mber)	4b. City, Town, or Location of Death	'	ec. County of Death	1
			Hebrew Home of Greater		Rockville If Under 1 Year   If Under 24 Hrs.	T = 0 + - ( D) +	Montg	
	Funeral		512 13 Security Number 6. Sex 1 M 2 F	7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		hplace (State or Foreign untry)
	Director		<del>519</del> 01-5401	93 Yrs.		November 3,	1913 Ok	lahoma
	pu ,		Usual Residence of Decedent	10c. City, Town or Lo	ncation			10d. Inside City Limits
	aryla show	_	10a. State 10b. County	Toc. Ony, Town of Ec				1 ☐ Yes 2X No
	9 W	5	Maryland Montgomery		Chevy Chase			
	th th	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f show the Madical Examinar must be traffilind at	a	8100 Connecticut Avenu	e, #1607	20815		United :	
	deal deal	Funeral		edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
9	after or the	3	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Gi	2 🖾 No	1 ☐ Yes 2 ☑ No Specify:			
21215-0036	urs a	þ	3 ☑ Widowed 4 ☐ Divorced Year or D	ates:	TE 100 Egg No Opeany.		WI.	nite
5	2 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of wor	kina	Kind of Business/	•
7	hin 7	pie	Elementary/Secondary (0-12) College (	1-4or 5+) life.	DO NOT use retired)		United St	tates
21	d wit	ПО	5-+	Pe	rsonel Manager		Governme	nt
ō	othe ent,	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maid	len Sumame)	
au	d be enta ked ic ev	To B	Andrew Jackson Wood		Ida	Elmira Whi	tmer	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show ther traumatic event, Ite Mydical Examiner must be indillind at	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, 2	Zip Code)
$\mathbf{Z}$	d 2 stharthartrau		Kathleen Tait / Daught	ar 1175	2 Easthampton Cir	cle. Charl	otte- NC	28277
e,	1 an Heal em 2 ther		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Location - City or	
ō	ges toff		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from	State Cemetery, cre		ly 12, 🖁 p	othoods	Maryland
Ë	Pa Imer Iury		`4 ☐ Donation 5 ☐ Other (Specify)	Cremat	orium Inc. 2	107		
Baltimore,	permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n eny injury or other traumatic event, Ite Mad once.		21. Signature of Funeral Service Licensee	M01433 B	2 Name and Address of Facility Ro ethesda-Chevy Cha ethesda, Maryland	se Inc. 75	mphrey Fi 57 Wiscon	nsin Avenue
			23a. Part1. Enter the disease, or complications that	caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
			shock, or heart failure. List only one cause on	each line. 🧳 👔				Onset and Death
	Physician	85 Y	Immediate Cause (Final disease or condition resulting in death)	Mad	Lomyolys	13		I month
	/Medical Examiner		Due to	(or as a consequence of):	/			1
	LAGITIMICI	L	Sequentially list conditions, b.	(				
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Exist Conditions (Cause (Disease or injury)	(or as a consequence of):				
	cute	Examin	that initiated events c.					
o,	e be executed /sician and e burial-transit	Ä	resulting in death) Last Due to	(or as a consequence of):				
760,	te be ysici	cal	d					
68	The law requires that the death certiticate be executed ate has been signed by the attending physician and page 2 should be detached tor use as the burial-transit	Physician/Medi					r	
Вох	ndin use	2		itcome of pregnancy birth 2  Fetal death 3	□Ectopic pregnancy		23d. Date of de	
	atte	cia	in the past 12 months?	nant at time of death 5	Other (specify)		Month	Day Year
P.O.	the c	ıysi	9 □ Unknown 9□ Unkr	nown				
	w requires that the de been signed by the should be detached	4	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	sign d be	P P				1 ☐ Yes	2 No 3 ₽	robably 4 Unknown
Division of Vital Records,	requ een houtk	Completed				24a. Was an	24h Mora a	utopsy findings available
ec	law las b	g				autopsy performed	prior to	completion of cause of
H	sician: The law s certiticate has b lirector, page 2 s	5				1 ☐ Yes 2		2 No
ita	Physician: this certitic	Be (	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)		
>	Physic this ce al dire	To		Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence	e 6 □Other (Spe	ecify)
ō	g Ph er th eral		27. Manner of Death 28a. Date	of Injury nth, Day Year) 28b. Time	of 28c. Injury at Work?	28d. Describe how i	njury occurred	
ō	nding F th. r: After e funera	atio	1 Natural 5 Pending 2 Accident investigation	.,,	M 1 Yes 2 No			
/is	Atte	ifici	3 Suicide 6 Could not be determined 28e. Plac	e of Injury - At home, farm, s ding, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S		ural Route Number,
Ö	afte Dire	ert	4 Homicide determined built	aling, etc. (Specify)		ony or rown, o	,	
_	spite lours neral	aC	29a. Certifier 1 Certifying Physician: To the	e best of my knowledge, dea	ith occurred at the time, date and place	e, and due to the caus	e(s) and manner a	s stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely tilled in by the funeral director, page	Medical Certification;	(Check only 2 Medicel Examiner: On the one)	basis of examination and/or inner stated.	29c. License number D0036710  p. Print) p. Trose RJ, Ro	urred at the time, date	and place, and du	e to the cause(s)
	o the o the ompl	Me	29b. Signature and title of certifier	_	29c. License number	29d.	Date signed (Mon	th, Day, Year)
	F X F 8		Andron Keens	Leat mo	D003671	's IT	114.9	2007
7	En 1		John John Joseph		Print	3,	7 /	,
6	20		30. Name and address of person who completed call	use of death (Item 23a) (Type	+ + . so Ad 1-	16:110	111	20852
			Hadrew Kundvar, M.	Degisterate Signatura	rivere has 100	CRUITIE	10/9	0
		ate	31. Date filed (Month, Day, Year) 32.	negistrat s Signature	•			
	Regist	rar	JUL I'Z LOUT ALLE	A No. Caller				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20ď7 Physician JIMONTH g 7:15A SIDNEY WEINBERG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TOWSON BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 08/16/1917 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Country **Funeral** Days Hours 214-01-2603 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 □Yes 2 No Science, Weinberry July 4,2007 Baltimore, Maryland 21215-6036 Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or items 23a or 28a-f sh mportant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified. Director MARGATE BROWARD Fi. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1055 COUNTRY CLUB DRIVE 33063 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married WHITE 1 □ Yes 2 No Specify. Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTING ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANKLIN WEINBERG BESSIE HARRY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) 6711 PARK HEIGHTS AVE., APT. #317, BALTIMORE, MD SYLVIA WEINBERG / WIFE 20b. Place of Disposition (Name of OHEB'), SHATOM other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/11/2007 | REISTERSTOWN, MD 5 ☐ Other (Specify) MEMORIAL PARK 4 Depation Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that oused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nat bleeding Physician mys asmountesh /Medical Die to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform 2 X00 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 3 ☐ Suicide determined 4 Homicide The strift of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Registrar JUL 1 2

AMON

31. Date filed (Month, Day, Year,

32. Registrar's Signature

1-) W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

N. Charles St TONSON MO

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1:25 AM MARY ELIZABETH ZEPP JULY 2007 8. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL CARROLL HOSPICE DOVE HOUSE WESTMINSTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days 1 □ M 2**X**□ F Yrs. 86 10/06/1920 MARYLAND Director 220-05-2938 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r 28a-f show notified at show 1 ☐ Yes 2 XNo Director WESTMINSTER MD CARROLL 10g. Citizen of What Country? 10e. Street and Number must be n 2810 OLD WASHINGTON RD. 21157 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

The marked other than "natural", or Items 23 ants: If item 27 is marked other than "natural", or Items 23 any or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify. <u>م</u> 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA WORKER SCHOOL 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GAVEN EDGAR METCALFE MARY ANN GLISAN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MELVIN F. ZEPP, JR. -SON 707 UNIONTOWN RD., WESTMINSTER, MD 21158 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ZION U.M. CHURCH CEM. 7/11/07 WESTMINSTER, MD H Familial Service Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition VEGCULAL 10 days Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths?
1 □ Yes 2 □ No 3 □Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Penale history LEFT SIDED 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Be Completed Chronic cholecustitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Accelerated huper tension 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{6}$  XOther (Specify)  $_{HOSPICE}$ Certification: To this 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and file of certifier 31660 07/09/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2911 STONER AVENUR 1 HOMAS CALVIN mania !

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL

32. Redistrar's Signature

		,	1 - State Registrar		Certificate of Death Reg. No. 2007 224						2241				
38	Dhysiai		1. Decedent's Name (First, Middle, La	st)		2. Date of Death , Month						Day	Year	3. Time of Death	
w.	Physici /Medic		Larry Brewer ART	Z							June		26	2007	13.20 PM
	Examin	er	4a. Facility Name (If not institution, giv				4b. City,		Location		:	. 4	4c. County		
			Washington County				If I Indo		ersto		0.01. (0.			hingt	
ĺ.	Funeral Director		220-34-0340	Sex 7. Age	74	a <i>st birthday)</i> Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Dec. 1	irth <i>ay, Yea</i> L <b>6,1</b>	.932	Coun	lace (State or Foreign try) yland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City Limits
	Maryla f sho ed at	ō	Maryland Washin	gton		agerst									1 ☐ Yes 2 ☑ No
	the N 28a-	Director	10e. Street and Number	Beon	- 110	260100	10f. Zir	Code				10g. (	Citizen of N	What Coun	itry?
	th with 23a or 1st be		116 Old National	Pike				2174	0				τ	USA	
	ems er mu	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		S. 13.	Was Dece	dent of H	ispanic Or an, Mexica	igin? (Spe n, Puerto l	cify Yes or N Rican, etc.)	0-		ce - Americ	
215-0036	be filed within 72 hours after death with the Maryland that Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	10		1 □ Yes	2 <b>2</b> No	Specify:				Specif	7.7	nite
ည်	72 h "natu dicai	etec	15. Decedent's E (Specify only highest gra			16a. Deced (Give	dent's Usu kind of wo DO NOT u	al Occup ork done i	ation during mos	st of workir	ng	16b.	Kind of B	usiness/Ind	dustry
12	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		mer	se retired	"				farm	ing	
0 0	filed Hygi other ent, t		17. Father's Name (First, Middle, Last						18. Moth	er's Name	(First, Middle	e, Maide	en Surnar	ne)	
Maryland	should be filed and Mental Hygin marked other matic event, til	To Be	Howard Artz							Cathe	rine E	Brew	er		
ary	S 8 8		19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Address	(Street	and Numb	er or Rura	l Route Numi	ber, City	y or Town,	, State, Zip	Code)
	is 1 and 2 of Health a item 27 is other trai		Joyce Artz - wife			116	01d N	Natio	nal :	Pike,	Hager	sto	wn, l	Md. 2	1740
ore O	iges 1 nt of He if iten or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	ce	ace of Dispo emetery, crei	matory or o	other plac			ate			- City or To	' =
Ē	Pages ment of tant: if its lury or o		4 □ Donation 5 □ Other (Specia		Res	t Hav				7/2/					Maryland
Baltimore,	permit. Page Department of important: if any injury or once,		21. Signature of Funeral Service Lice	nsee Mary	$O_{i,j}$		2. Name ar 15 🙃				INNICH , Hage				
	1 5 4		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused	the death.								Own,	Mu. A	Approximate
	Dhysician		Immediate Cause (Final	one cause on each lin	ie.	2 1	000000		7	.1 /	Con	-1			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	70	Car	016	2   j	NTAI	CA	$10\sim$		
	Examiner			Lorone	•	acl	en	di	eus	٥					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		ence of):	1								_
	ecuted nd transi	Examin	that initiated events	c											
Š,	ertificate be executed ding physician and se as the burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):									
<b>68/6U</b> ,	physic the t	Medical		d	_										
×	certifi iding ise as		IF FEMALE:	23c. If yes, outcome	of pregnar	ncv						, III	l asa Da	ite of delive	200
90	that the death certificed by the attending p	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4∐Pregnant at	2 🗌 Fetal	death 3L	]Ectopic p ] Other <i>(sp</i>		· 					onth	Day Year
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Š,	as tha gned se de	by P	Part II. Other significant conditions	contributing to death bu	it not resul	ting in the u	nderlying o	ause give	en in Part i	l.	23e. Did	tobacco	o use cont	tribute to th	ne cause of death?
<u> </u>	w requires to been signer should be	ted	atrial Garilla	FIOL DY	por	fem Si	1	1441	TON	jen	1 🗆	Yes	<b>€</b> No	3 ☐ Prob	ably 4 ∐Unknown
Hecord	aw s b	Completed	chabetes mell	dus, Ly	STIP	dem!	a				24a. Was	opsy		prior to cor	psy findings available npletion of cause of
-		Co									perf 1∐ Yes	formed?		death? 1 ☐ Yes	2 No
VITA	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Oth		e of Death	(Check only	one)			
0	iing Physician:  After this certific funeral director,	<u>۲</u>	1 Yes ZN No  27. Manner of Death	1 ☐ Inpatie		R/Outpatier 28b. Time of		JA	4 🗆 Ni		ne 5 Res 28d. Describe				y)
0	ding h. After fune	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	M	28c. Injur Worl 1 □	رې Yes 2⊡		ou. Describe	11047 111	jury occur	160	
JIVISION	Attender death	fica	3 Suicide 6 Could not b	e 28e. Place of inju	ry - At hor	ne, farm, str	eet, factor	y, office		2	28f. Location	(Street	and Numb	ber or Rura	l Route Number,
5	tal or s afte al Dir ed in	Certification:	4 🗆 Homicide	building, etc	. (Эреспу)	<b>'</b>					City or To	own, Sta	ate)		
	To the Hospital or Attending Physician: whim 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical (	29a. Certifier Certifying Pt (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examinati	/ledge, deatl on and/or in	h occurred vestigation	at the tir n, in my o	ne, date a pinion, de	nd place, a ath occurre	and due to the ed at the time	e cause e, date a	(s) and mand place,	anner as si and due to	tated. the cause(s)
	To the vithin ?	Me	29b. Signature and title of certifier	2 and marrier sta				c. Licens	number,			29d. D	Date signe	ed (Month,	Day, Year)
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YΖ	Her		30. Name and address of person who	1.00	/	7	1	v	^		; /	- 1	7 ,	~ (	Day, Year) 007 ) 21742
0	H- 8 Sta	te	31. Date filed (Month. Day. Year)	(^) 134_ 32_Registra		en~Suure	g/Var	la	Avei	rue	riage	1)4	OWN	1.12	~ ~ 1 / 1 ~
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07-04679 Tyler Adams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

yler Adams	1- For State	•	State	e of Marylar		rtment of tificate of		d Menta	al Hygie		2 U g. No.	07 2241
Physician ledical Examine	1. Deceden	it's Name (Fir							Mo	ate of Death onth ne 19, 2	Day Year	3. Time of Death 1600 hrs
· •	4a. Facility		institution, g	ive street and num	ber)	41	c. City, Town, or Baltimore	Location of		110 10, 2	4c. County of De	ath
Funeral Director	5. Social Se	ecurity Numb	er 6.	Sex 7	. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Yea Months Day		Min.			Birthplace (State or reign Country)
	Usual Resi	dence of Dec	edent	A 2		Town or Location				701. 4	27, 1702	10d. Inside City Limits
d 10w any	10a. State	106.	County Tr A	LBOT	Toc. City,	EAST						1 X Yes 2 No
the Maryland a or 28a-f show	10e. Street	and Number		прот		IASIC	10f, Zip Code			10	g. Citizen of What C	ountry?
th the Maryland 23a or 28a-f sho notified at once.		SALMO	N AVE.				2160					SA
er death wi	3 10/10	er Married			dent Ever in U. ces? 2 <b>X</b> No	If Ye	Decedent of His s, specify Cubar	n, Mexican, F			14. Race - An White, etc	merican Indian, Black, c. WHITE
atural"	15 Dece			or Dates: only highest grade	completed)	16a. Decedent	s Usual Occupa	tion (Give ki		lone	16b. Kind of Busine	ss/industry
0036 within 72 hour giene. her than "natu-Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+) TREE PRUNER  College (1-4 or 5+)											CULTURE
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	)   17. Father	17. Patrier's Name (11st, Middle, East)									Maiden Surname)	
212 lould be d Ment s mark tic ever				(Type, Print )		W/		et and Numb	er or Rural I	Route Num	ber, City or Town, S	
MD and 2 sho salth and 2 sho san 27 is raumat		Y S. D		OTHER	20b I	2524 Place of Disposi			. RD.,		HING CREEN	<b>K, MD 21634</b> v or Town. State
Baltimore, permit. Pages I at Department of Her Important: If ite	1 X Buri	ial 2 (	remation 3		m State	crematory or oth	er place)			3/2001		, MARYLAND
Saltin emit. P epartme nportar ijury or		ure of Punera			1100							AL HOME PA
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Box 68760, standard the attending physic of for use as the bur	IF FEMALE	E: lecedent preg 2 months?	nant in the	23c. If yes, o	utcome of preg		al death 3	Ectopic	pregnancy		23d. Date of deli Month	ivery Day <b>Y</b> ear
). Box 6876 the death certificate by the attending phy ched for use as the bruseling and	past 1.		Unkno	-	int at time of de	eath 5 Oth	ner (Specify)					
P.O. B as that the d igned by the detached by the detached by the detached by the detached by the Detached by the Detached by the Detached		ner significa	nt condition	s contributing to		esulting in the u	nderlying cause	given in Par	t I.			e to the cause of death?
ords, P.C w requires that is been signed be should be deta									—	1 Yes		Probably 4 Unknown e autopsy findings available
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Division of Vital Records, tat or Attending Physician: The law requires are death.  al Director: After this certificate has been seen in by the funeral director, page 2 should built only the funeral director.	27. Manne	r of Death atural 5	Pending	28a. Date of (Month, Jun 17, 2	of Injury Day Year) 2007	28b. Time of Ir 0149 hrs		ury at Work? Yes 2 ✔	Per		how injury occurred struck by auto	
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Divisi Hospital or At 24 hours after d Funeral Direct stely filled in by	4 Hc	omicide	determi	ned (Specify)		ıd / Highway					Ave. & 32 St., Oce	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the hineral director, page 2 should be detached for use as the burial - transfacional Certification. To De Completed the Division Medical E-			tifying Phys Iical Examii	ner:On the basis o	f examination a	dge, death occur and/or investigat	red at the time, of ion, in my opinio	date and place on, death occ	ce, and due curred at the	to the caus time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To To COT	29b. Signa	ture and title	of certifier	and manner st	ateu.			se number				(Month, Day, Year)
		sole			ur		0.0	.M.E.			June 20, 200	/
6	Tash	a Greenb	erg MD.	no completed caus Assistant Me			Penn Street	, Baltimor	e, MD 21	1201		
Stat		led (Month, E		32. Re	gi krar's Signat	ure	land -					
Registra	ar	J	OIL Y	W COOK		15						

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June 740 M CURTIS F. ALLEN 200 Facility Name (If not institution, give street and number, Town, or Location of Death 4c. County of Death Hospital at Talbot lemorial Easton touston If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Days Months 1XM 2□F NEW YORK 87 MAY 8, 1920 135-12-9545 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 SHANNON TERRACE 21601 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify. Specify: WHITE 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ TEACHER PUBLIC EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NATHAN H.E. ALLEN HAZEL FULLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA ALLEN/DAUGHTER RT 412, APT 4 RIEGELSVILLE, PA 18077 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR. 6/15/2007 STEVENSVILLE, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licen Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) noll vessel Sequentially list our diffuse, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mendal Hyglene. Department of Health and Mendal Hyglene. Inaturally or Items 23a or 28a-f show Important; If item 27 Is marked other than "naturall" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

/Medical

Director

Funeral

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Completed

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The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p Certificat

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in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given	in Part I. 23e. Did tobacc	o use contribute to the cause of death?
aspiration	polumera	1 🗆 Yes	2 No 3 Probably 4 Unknown
Chresie n	eral fallure	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Hypriters	V.	1  Yes 2 4	
25. Was case referred to medical examiner?	2	26. Place of Death (Check only one)	
1 ☐ Yes 20 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:	4 ☐ Nursing Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigat			ljury occurred
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	hysician: To the best of my knowledge, death occurred at the time miner: On the basis of examination and/or investigation, in my opin and manner stated.		

29c, License number

29d. Date signed (Month, Day, Year)

10+VA

State

Medical

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Restrar's Signature

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 991. : 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month June 24. 2007 0920 Α Themistocles G. Aposporos 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **1**X M 2 □ F March 30,1926 New York 084-20-3964 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4717 Boiling Brook Parkway 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 1944 If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Teacher / Associate Professor Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Panayiota Antonakas George Aposporos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Harriet Aposporos</u> / Wife 4717 Boiling Brook Pky. Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate Of Heaven Cem. | June 29,07 | Silver Spring, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. ille 5130 Wisconsin Ave. N.W. Washington D.C. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) m.n Ardia Due to (or as a consequence of): min Due to (of as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an

**Physician** /Medical Examiner

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After this funeral

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

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Completed

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Certification: To

Medical

death certificate be executed

P.O. Box 68760

Division or Vital Records,

Physician:

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-i shov any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1□ Yes 2 1No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 2 NO

Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Tes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of contifier

6 ☐ Could not be

med Direch

29c. License number 0050410

Philip UR Chney,

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11chael 31. Date filed (Month, Day, Year) 2

Registrar DHMH 17 Rev 1/2001

State

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 10:07 A M ATLA PATRICIA BRAWNER JUNE 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHEVERLY PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 5. 1932 1 □ M 2 □ F AUGUST 26. 578-42-5760 74 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shov dical Examiner must be notifled at 1 ☐Yes 2 ☐ No Directo MARYLAND BRYANS ROAD CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 214 GENTRY COURT 20616 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK <u>Ş</u> 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11TH GRADE CHILD CARE DAY CARE 12 should be filed w and Mental Hygien 'Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RAYMOND JAMES KING BLANCHE IOLA KING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any injury or other trau JACQUELINE HARLEY / DAUGHTER 10003 ANGORA TERRACE, CHELTENHAM, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY JUNE 30, 2007 CLINTON, MARYLAND 4 Donation 5 Dother (Specify) 21. Survey of Fundal Marke Licenses 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. LIZDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA OF THE LEFT BREAST WITH METASTASIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 2√ No 3 Probably 4 Unknown Completed HYPERTINGLYCERIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page ; performed? Yes 2**X** No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 2☐ ER/Outpatient 3☐ DOA ဥ 1 Inpatient s after death. I Director: After this of in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0 To the Hospital within 24 hours a To the Funeral C

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

or Vital

Division

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

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1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

JUNE 25, 2007

completed cause of doth (Item 23a) (Type, Print) 30. Name and address of person wh

and manner stated.

GLENN R. EDGECOMBE, MD 7700 OLD BRANCH AVENUE, CLINTON, MARYLAND

31. Date filed (Month, Day, Year) JUN 2 7 2007 32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** JUNIOS /Medical 4c. County of Death 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death give street Examiner WOSHINSTON MSP CUNIU laacisto Washing If Under 24 Hrs. 5. Social Security Number 6. Sex 1 XM 2 F If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) (In yrs. last birthday) **Funeral** Year) Days Months Hours 75 Director 15 1932 Maryland 216-30-3016 June Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Hagerstown 1 ☐ Yes 2 X No Maryland Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21742 19823 Bennie Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 El Yes 2 □ No 12-3-52 If Yes, Give Year or Dates: 12-2-54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Letter Carrier 12 18. Mother's Name (First, Middle, Maiden Surname) Ora Louise Gilbert Byers 17. Father's Name (First, Middle, Last) Be Paul Ray Byers, Sr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19823 Bennie Drive Hagerstown Maryland 21742 Martha Jane Byers - wife Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 7-3-2007 Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No þ Completed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

Be

Certification:

Medical

9 ∐ Unknown			
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
detre ex	MONEY WITH NO CINICOL	24a. Was an autopsy performed2 1∐ Yes 2201	
25. Was case referred to medical	26. Place of Death (C	Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)
27. Nanner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?	d. Describe how inj	ury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred		

29d. Date signed (Month, Day, Year)

5 H11+1

State Registrar

31. Date filed (Month, Day, Year) JUL 0 3 2007

30. Name and address of person who completed case

BASON

29b. Signature and title of certifier

UNITE

e of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day June 2007 **Physician** 0505 Baynard merson /Medical 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton memorial Eastor Talbot Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Days Months Hours 18-30-2196 72 Director 08-17-1934 Md. esidence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 No other traumatic event, the Medical Examiner must be notified Director Denton Md aroline 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò ne Apt.

12. Was Decedent Ever in U.S.
Armed Forces? USA 14. Race - American Indian, or items 23a aroline 71629 permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ...... any bijury or other traumatic excess. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify. þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmhand Farmina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emerson Baynard, Sr. 19a. Informant's Name/Relationship (Type Print) Viola Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Figueroa/sister 203 Caroline Denton, Md. 21629

20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Grove Cem 06-22-07 Denton, md. 4 □ Donation 5 □ Other (Specify) Spring 22. Name and Address of Facility

Bennie Smith Funcial Home

426 pover 5+. Easton, ma 2160

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YSTOL disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy perform 28 No Division or Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) +2 ,00 MING DACK 31. Date filed Month, Day, Year) State

Registrar

**JUN 25** 

2007

1 - For State Registrar

Certificate of Death

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No	1	65	6	100	la 10	2	
- 6	1			3		lv.	

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, th. Medi-al Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician

/Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

		1. Decedent's Name	e (First, Middle,	Last)							2. Date of D		Voor	3. Time of	Death
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any injury or other traumatic event, the Medical Examiner must be notified at once.	cto	PA	Frank1:	Ln	Cham	bersb									2 110
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	-	28a Part Enter t	he disease, or o	omplications that	caused the death								L, FID A	Approximat	
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	y P	Part II. Other signi	ficant condition	s contributing to	death but not res	ulting in the	underlying	cause giv	en in Part	t I.	23e. Dio	d tobacco u	ise contribute	to the cause of	death?
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	٠ <u>۲</u>	27. Manner of Deat		28a. Date		ER/Outpati 28b. Time		28c. Inju	4 L N		ne 5 ⊔ He 28d. Describ		6 □Other (Sp v occurred	ecity)	
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	Me	29b. Signature and	title of certifier				29	c. Licens	se number	Г		29d. Da	te signed (Moi	nth, Day, Year)	
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	Examin		4a. Facility Name (If not institution, give Cedar Hill Assisted			Acci		Location of	Death			Sarrett	
			5. Social Security Number 6. Se		irthday)	If Under	1 Year	If Under 2		8. Date of Birt	h ,	9. Birt	hplace (State or Foreign
	Funeral Director			™ 2 <b>X</b> )F	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept.5			st Virginia
			Usual Residence of Decedent										10d. Inside City Limits
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Maryland			19a. Informant's Nama/Relationship (T	ype, Print) 19	9b. Maili	ng Address	(Street a	nd Numbe	r or Rura	Route Numb	er, City or	Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Barbara Hornyak/da	ughter 6	09 8	South	ern 1	orive	, ME	. цаке	Park,	, עויו	21330
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Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of once.			mai	Ne		Fune	eral	Home	s, P.A.	, Gra	iller : antsvi	Street lle, MD 2153
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do one cause on each line.	o not en	ter the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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68	rtifica ng ph s as th		IF FEMALE:										
Вох	death certifica attending phater use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		⊒Ectopic pr					23	3d. Date of de Month	livery Day Year
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Vital	ician; Th certificate rector, paç	Φ	25. Was case referred to medical					26. Place	of Death	(Check only			
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	niner: On the basis of examination and manner stated.	and/or in			pinion, dea e number	ath occurr	ed at the time			e to the cause(s)  with, Day, Year)
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	St Regist	ate	31. Date filed (Month, Day, Year)	32. Tegistrar's Signature		Possell	r						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** eNDER 1304 M 2007  $\cdot V i N$ 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOMERFORD TUNA POUS RUNDEL B. Date of Birth (Month, Day, Ye. June 18, 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 72 219-30-1150 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 203 Drum Avenue South USA 21122 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No 1954− If Yes, Give Year or Dates: 1962 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: 3 Widowed 4 Divorced 1962 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Telephone Co. Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Bender Leathea Lowman ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; if item 27 Is any Injury or other trains Betty Bender/Wife 203 Drum Avenue South, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 19, 1 ☐ Burial 2 X Cremation al from St Metro Crematory Baltimore, MD 2007 4 ☐ Donation 5 Other (Specify) Barranco & Sons, P.A. Severna Park Funeral How 495 Gov. Ritchie Hwy, Severna Park, MD 21146 art : nter the disease, or co shock, or heart failure. List on Do not enter the mode of dying, such as cardiac or respiratory arrest, lanmediate Cal se (Final disease or condition resulting in death) YOMES **Physician** DeMentiA DVANCE /Medical to (or as a consequence of): Examiner Sequentially list conditions, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed as the burial-trans attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MELLITUS 3☑ No NABETUS 1 ☐ Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perforn certificate 2∐No 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes Z☐ No Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpatient 3 □ DOA 6 Other (Specify) 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Yes 2 No 2 Accident the Funeral Director: upletely filled in by the 3 ☐ Suicide 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier

State Registrar h, Day, Year, JUN 2

6 2007

TERMSHIGHMAY MILLESUILLE, MI

			1- State of Maryland / De State of Maryland / De	epartment of Heal Certificate of Deal			iene 2007	22421
ij.	S. Dharaisi	ð	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	9	3. Time of Death
Á	Physicia /Medic		Jimmy Boggs			June 22	, 2007	(0°22AM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca	ation of Death		4c. County of Deat	
1			Doctor's Community Hospita1  5. Social Security Number   6. Sex   7. Age (In yrs. last birtha	Lanham	Under 24 Hrs.	8. Date of Birth	Prince G	balana (Otata a Familia
П	Funeral Director		227-68-9710 1 1 1 2 F 61 Yrs	Months Days Ho	ours Min.	(Month, Day, Decembe	r 3,1945	Kentucky
	σ		Usual Residence of Decedent				,,	
	arylar show d at	ō	10a. State 10b. County 10c. City, Town o					10d. Inside City Limits 1   1   Yes 2   No
	the M 28a-f otifie	Director	MD Prince Georges Lanha	10f. Zip Code		1 4/	Og. Citizen of What Co	
	with sa or the r		9318 Wyatt Drive			"	-	unity?
	death ms 2:	Funeral		20706  13. Was Decedent of Hispan If Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No-	USA 14. Race - Ame	
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		1 Never Married 2 Married 1 Yes 2 No		nexican, Puerto i Decify:	rican, etc.)	Black, White Specify: W	
21215-0036	nours ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					ender on the
2	n 72   "nat	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation Give kind of work done during fe. DO NOT use retired)	n ng most of workir	ng	16b. Kind of Business/	Industry
212	I withi jiene. r than the M	шо	Elementary/Secondary (0-12) College (1-4or 5+) ""	Roofer			Construct	tion
פ	0 = 0 %	Be C	17. Father's Name (First, Middle, Last)	18.	Mother's Name	(First, Middle, M	faiden Surname)	
<u>S</u>	Ments Ments arked attc e	10	Bradley Boggs		Matti	e Scoti	t	
Maryland	12 sho			lailing Address (Street and N				Zip Code)
	1 and Healt em 2		20a. Method of Disposition 20b. Place of Di	8 Wyatt Driv		am, MD	20706 20c. Location - City or	Town State
JOIL L	ages ent of it; If it		1 X Burial 2 □ Cremation 3 □ Removal from State Lakemon	crematory or other place) nt Memorial	6/28	/2007	Davidsonv	
altimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important; If item 27 Is marked any injury or other traumatic enone.		21. Signature of Funeral Service Licensee	22. Name and Address of	F104-		Evans Funer	
<u></u>	De m	1	· KNUS	16000 Annap	olis Ro	ad Bow	ie, MD 2071	15
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	tic Cardis	VASCON	Law He	act Dise	Onset and Death
1	/Medical Examiner		Due to (or as a consequence of):					
		-e	Sequentially list conditions, if any, leading to immediate b.  Due to (or de a consequence of):					
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Ō,	e exe( ian ar ırial-tı		resulting in death) Last Due to (or as a consequence of):					
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Box	atten for u	Physician/M		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
0.	t the c by the	hysi	9 ☐ Unknown					
_	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in	Part I.	23e. Did tob	acco use contribute to	_
ord	w require been sig should b					1 🗆 Ye	s 2 No 3 Pr	obably 4 Johknown
Records,	e faw has b	Completed				24a. Was ar autops	v prior to	topsy findings available completion of cause of
_	ician: The lav certificate has rector, page 2:					perform	ned? death? 1☐Yes	2□ No
Viital	sicial certification irecto	o Be	25. Was case referred to medical example?  1. ✓ Yes 2 □ No	Other:		(Check only one		
0	g Phy er this eral d	-	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at			nce 6 □Other (Sperwinjury occurred	orry)
jo	ath. or: Aft	atio	2 Accident investigation	M 1 Yes	2 🗆 No			
Division or	or Atter de lirecte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	2	8f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
	pltal of uns all eral D		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, d	anth accurred at the time of	late and place of	and due to the co		-t-t-d
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, d (Check only one)  Certifying Physician: To the best of my knowledge, d and manner stated.	r investigation, in my opinio	on, death occurre	ed at the time, da	ate and place, and due	to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	29c. License nun	mber	29	9d. Date signed (Mont	h, Day, Year)
	900		Inhadas of with to	15005	5927	J	une 25,	2007
1	OBr		30. Name and address of person who completed cause of death (Item 23a) (Ty	no Brint)	ph= -	4	and and	
	77		SALVA der Sylvater, 300/Hospita 31. Date filed (Month, Day, Year)  32. Palistrar's Signature	1 Dire,	June	01 1	any and	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 6 2007	had !			•	

07-04	1660
John	Baumgartner

7-04660		Please Type or Print in Black Indelii					gible.	67 2252		
ohn Baumgartne	1	State of Maryland / Departme - For State Certifica egistrar			nd Menta		eg. No.	and the distance		
Physician	1/	l. Decedent's Name (First, Middle,Last)				2. Date of Dea Month		3. Time of Death		
Medical Examine		John Baumgartner la. Facility Name (if not institution, give street and number)	- 14	b. City, Town, o	r Looding of F	June 18,	2007 4c. County of De	1525 hrs		
		8205 Washington Blvd. Lot 17	"	Jessup	or Location of L	eaui	Howard	saur		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	iday)	If Under 1 Ye		_	rth(MM/DD/YYYY) g.	Birthplace (State or reign		
Director		283-52-4116   1XM 2 F   54	Yrs.	Months Da	ys Hours	Min. 2/1	/1953	Country) Ohio		
<u> </u>		Usual Residence of Decedent	or Locatio	OD.				10d. Inside City Limits		
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vlaryland 28a-f show any d at once.	탏	10e. Street and Number	J	essup 10f. Zip Code			10g. Citizen of What (			
3036 within 72 hours after death with the Maryland leine. ter than "natural", or items 23a or 28a-f sho Madical Examiner must be notified at once.	<u></u>	MD   Howard   100. Street and Number   8201 Washington Blvd Lot 17	20794				USA			
with 1	ᅙ	11. Marital Status 12. Was Decedent Ever in U.S.		Decedent of H	lispanic Origin	(Specify Yes or N	o- 14. Race - Ar	merican Indian, Black,		
death or iter must	Funeral	1 Never Married 2 Married Armed Forces?	If Ye	es, specify Cuba	White, et	c.				
s after ral",	ఎ	3 Widowed 4 X Divorced If Yes, Give Year 79 - 95		Specify:	White					
hour "natu	冒	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Indus								
336 thin 72 than cdical	Completed	12 Soldier US Army								
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner, must be notified at once.	탉	17. Father's Name (First, Middle, Last)				Name (First, Middle,				
121 I be fill ental J urked	8	John Howard Baumgartner Blanche Marie Brahnam								
and 2 should be fi and 2 should be fi fealth and Mental tem 27 is marked traumatic event.	- J	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (								
, MD and 2 sho ealth and tem 27 is traumati	1			Cuire D		vern, MD 2	21144 20c. Location - Cit	y or Town, State		
Termatory of other place)								o MD		
Itim nit Pa artmen ortani	1	4 Donation 5 Other Specify: 21. Signature of Juneral Service Ligensee					Baltimor			
Balti permit Departm Imports		oat 1 11	12	Ridge1	y Ave.	Annapolis	Funeral Hos,MD 21401	me, P.A.		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.						Approximate Interval Between Onset and		
/Medical Examiner	i	Immediate Cause (Final disease a. Hypertensive Atherosclerotic	Cardi	ovascular D	isease			Death		
	-	or condition resulting in death)  Due to (or as a consequence of):								
	<u>ا</u> مِ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death), last  Due to (or as a consequence of):						-		
		events resulting in death) Last Due to (or as a consequence of):  d.								
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Box 68760 e death certificate by the attending physi ed for use as the bu	Ě	IF FEMALE: 23c. If yes, outcome of pregnancy				-	23d. Date of del			
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Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by all Director: After this director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	틸	1 V Natural 5 Pending (Month, Day,Year)			njury at Work? Yes 2 N					
VISION Attender Pirecto	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other Scene  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 1 DOA 28b. Time of Injury - At home, farm, street, factory, office building, etc. 28b. Time of Injury - At home, farm, street, factory, office building, etc. 28c. Injury at Work? 1 Yes 2 No 28b. Time of Injury - At home, farm, street, factory, office building, etc. 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred									
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	edical	29a. Certifier (Check only orne) 2 Medical Examiner: On the basis of examination and/or in								
To Tro	Med	and manner stated.  29b. Signature and title of certifier			nse number			(Month, Day, Year)		
C V				0.0	C.M.E.		June 19, 200	7		

Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 6 2007 State Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

-04794 j Kumar Bhall	а	State of Maryland / Department of Health and Mental Hy		ole.	11 33+2
		1- For State Certificate of Death	Reg.	No.	
Physicia edical Exami		1. Decedent's Name (First, Middle, Last)  Raj Kumar Bhalla	2. Date of Death  Month D June 23, 200	ay Year )7	3. Time of Death 2135 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 14714 Candy Hill Road Upper Marlboro		4c. County of Dear Prince Georg	
Funeral Director		5. Social Security Number 217-13-8414 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth()	MM/DD/YYYY) 9. B 7 2 Fore C	rthplace(State or gn Cheverly, Moonn(Cheverly)
nd show any ice.	ır	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 X Yes 2 No
the Maryla Sa or 28a-f	Director	10e. Street and Number 3405 Taylor Street 10f. Zip Code 20722		Citizen of What Co ited Stat	
Baltimore, MD 21215-0036  pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  3 Widowed  4 Divorced If Yes, Give Yeer  1 Yes, Give Yeer  1 Yes, Give Yeer  1 Yes, Give Yeer  1 Yes, Give Yeer  1 Yes, Give Yeer  1 Yes, Give Yeer		White, etc.	rican Indian, Black, White
2 hours after "natural".	eted by	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  1 Yes 2X No specify:  1 1 Yes 2X No specify:  16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use reting the specific of the specific		Specify:	
5-0036 led within 7 Hygiene. other than the Medica	Completed	2 Police Officer  17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma		cement
121 Id be fil Aental F narked event,	o Be	Lal C. Bhalla  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F			te Zin Code)
MD 2 2 shou 2 shou 27 is n 1 matic	To	Wendy J. Bhalla (wife) 3405 Taylor Street B			
more, Pages 1 and cent of Healt internal interna		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fort Lincoln Crematory 7—	3-2007 В	rentwood,	MD
Balti permit. Departm Importa		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Fo  3401 Bladensburg R	oad Bre	ntwood, M	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):			Doug
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e executed Sian and rial - transit		d.			
60, ate be er hysician e burial	Medic	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery
i, P.O. Box 68760, ires that the death certificate be signed by the attending physici be detached for use as the buri	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnated by the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown	ancy	Month	Day Year
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tal Records, rian: The law requir certificate has been s	Completed		24a. Was an autopsy perform	prior to	
Vital R ysician: T his certific director, p	Be C	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing			
1 of Vital ling Physician: After this certifuncral director	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho		
e fi	Certification:	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str	reet and Number or	n stuck fixed objects  Rural Route Number, City
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To the   within 2 To the   complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date ar	nd place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier  O.C.M.E.	ŀ	29d. Date signed (A	ionth, Day, Year)
300		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimol	re, MD 21201		
		the same of the sa			

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Mattie Louise Byrd 3:00 Ам June 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number)
Collington Episcopal Life (
Community Nursing Home 4c. County of Death 4b. City, Town, or Location of Death Examiner Care Mitchellville Prince George's 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y)
July 31, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 K F 577-07-1692 88 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 'natural", or items 23a or 28a-f show Mitchellville 1X Yes 2 No MD Director Prince George's with the 10g. Citizen of What Country? 10e. Street and Number 20721 USA 10450 Lottsford Road Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after anns of Health and Mental Hygiene. Interest if item 27 is marked other than "natural", or ite any or other traumatic event, the Mr and Examine any or other traumatic event, the Mr and Examine. 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Own Home College (1-4or 5+) Homemaker 12 Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James E. Corey Sallie Morgan P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401 Carol Weichert/Daughter 136 Spring Place Way, Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan CrematoryJune 28, 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Gasch's Funeral Home, P.A. Hyattsville, MD 21. Sign aure of Funeral Service Licensee 4739 Baltimore Avenue MOIM91 Cheryll 234. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Cancer - Primary Unknown 2 months **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, physician the buria Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 X Natural ours after death.
neral Director; A
filled in by the fu 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

JUN 2 8 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Don H. Yablonowitz, 7404 Executive Place, #502, Seabrook, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

5

D25079

June 28, 2007

20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

State

Registrar

31. Date filed (Month, Day, Year)

7 2007

Registrar's Signature

			For State	State	of Marylar	-	artment of H		Mental Hy	giene			
	_		Registrar  1. Decedent's Name (First, Middle	( ant)		Ce	rtificate of	Death	0.00	Reg. No.	047	3. Time of Death	
	Physici: /Medic		Cas	L		Bowlar		2. Date of De Month July	7, Day 2	200 <b>7</b> ear	6:45pm M		
	Examin	er	4a. Facility Name (If not institution 5820 Butterf)	-	ımber)		4b. City, Town, o	th	4c. County of Death Frederick				
_	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Bir	th	9. Birthi	place (State or Foreign	
	Director		211-28-9890	1 <b>∑</b> M 2□F	70	Yrs.	Months Days	Hours Min.	Jan 6,	1937	Wes	t Virginia	
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits	
	Maryli f sho ied at	to		lerick		* .	erick					1 X Yes 2 □ No	
	nr 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?	
	23a o ust be	alD	5820 Butterfly	Lane			23	L <b>7</b> 03		U.	S.A.		
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2፟ Marr 3 □ Widowed 4 □ Divorced		2 No 19	00-	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Americ Black, White, ecify: Wh		
ה ה	72 ho natur ilcal i	eted	15. Decedent (Specify only highes		)	16a. Dece	dent's Usual Occup	ation	nrkina	16b. Kind o	of Business/In	ndustry	
7	vithin ne.	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		kind of work done DO NOT use retired inum work		g	Fact	alco A	luminum	
7	filed v Hygie Ither t		17. Father's Name (First, Middle,	Last)		rizan.	IIIdiii WOIN		me (First, Middle			I CHILLICHI	
ylan	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be	Leeland	Α			wland	Lillian	a Albi	ıtus	Ga	rfield	
20	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationsl Mrs. Arline Boy		fe		ng Address <i>(Street</i> D Butterf					,	
บั	of Hea	-	20a. Method of Disposition		20b.		osition (Name of matory or other place		Date		ion - City or T		
	Pages nent of h ant: If Ite ury or o		1 🛣 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		i State L	Olivet	Cemetery	Jul 10				Maryland	
Dallillo	permit. Departn Importa any Inju		21. Signature of Funeral Service	Chein	ノ MO07	06 1	Name and Addre Keeney 06 East C	ss of Eacility & Basfor Church St	d P.A. Frede	Funera	l Home Maryla	nd 21 <b>7</b> 01	
			23a. Pa N Enter the disease, or shock, or head ailure. List Immediate Cause (Final									Approximate Interval Between Onset and Death	
,	Physician /Medical		disease or condition resulting in death)		sive tr		onal cell	cancer	of kidn	ey			
	Examiner		So wertially list over this ex-		ple bon		stases						
	pe sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		o (or as a consection as a con	quence of):							
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C	(or as a conse	quence of):					-		
0/00,	re be e	dical E		d									
0	ntifical ng phy as th	Medi	IF FEMALE:										
O. DOX	The law requires that the death certificate has been signed by the attending is agge 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live	utcome pf pregr birth 2  Fet gnant at time of nown	al death 3	□Ectopic pregnanc	<i>y</i>		23d.	. Date of deliv Month	rery Day Year	
7	s that ined by	by Ph	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to 1	the cause of death?	
ő	equire en sig ould b	ted b							10	Yes 2 <b>K</b> N	lo 3 Pro	babiy 4 Unknown	
al necords,	: The law r cate has be ; page 2 sh	Completed							24a. Was auto perfo 1∐ Yes		prior to co death?	opsy findings available ompletion of cause of 2 No	
N I G	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	N	150/0 4-5	ot 3 DOA Oth	et.	ath (Check only				
5	g Phy er this eral di	J: To	27. Manner of Death	28a. Date	of Injury	28b. Time of	IL SU DOA	4 LI Nursing I	Home 5 Res 28d. Describe			ify)	
2	Attending r death. ector: After by the funer	atio	1 Natural 5 Pendin 2 Accident investig	ation	nth, Day Year)	Injury		k? Yes 2 □ No					
Division	I or Atte after de Directo	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 28e. Plac	e of injury - At h ding, etc. (Spec	nome, farm, st	reet, factory, office		28f. Location ( City or To	Street and N wn, State)	umber or Run	al Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier 1 X CertifyIn  (Check only one) 2 Medical	Examiner: On the	ne best of my kn basis of examin nner stated.	owledge, deat ation and/or ir	th occurred at the ti	me, date and place	e, and due to the curred at the time	cause(s) and , date and pla	d manner as s	stated. to the cause(s)	
)	To th withir To th comp	Me	29b. Signature and title of certifier		/		29c. Licens				igned (Month,		
)				S	~ "	47	D14	626		July 9, 2007			
			30. Name and address of person P. Gregory Raus	ch, M.D.	, 501 W	est Sev		eet, Fre	derick,	Maryla	and 21	701-4507	
	Sta Registr		31. Date filed (Month, Day, Year)	107	Registrar's Sign	ature	Le.						

07-0490	8
William	Childers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

William Childers		For State	ate of Maryland		rtment of I tificate of L		a Mental Hy		g, No.	UU	1 1-6-16	
Physician/	_	egistrar Decedent's Name (First, Middle	e,Last)					2. Date of Deat	h	rear	3. Time of Death 0728 hrs	
Medical Examine		William E. Chi			Las	Cit. Terre or	Leasting of Dooth	Month June 28, 2		ty of Death		
\$	4	a. Facility Name (if not institution Union Hospital	n, give street and numbe	7)		Elkton	Location of Death		Cecil	ty or beau		
Funeral	5	Social Security Number	6. Sex 7. A	ge (In yrs. la	st birthday)	If Under 1 Yea		8. Date of Birt	th (MM/DD/YY	YY) 9. Bir Foreig	thplace (State or	
Director		228-39-3042	1 X M 2 F	20	Yrs.	Months Day	s Hours Min.	Nov.	11, 198	6 co	<sup>untry)</sup> Virginia	
ń	_	sual Residence of Decedent  0a, State 10b, County	21	10c. City,	Town or Location	n				-	10d. Inside City Limits	
L Ge wa			Cecil	E	Elkton						1 Yes 2 X No	
the Maryland a or 28a-f show iffied at once.	3 1	0e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Cou	ntry?	
th the Maryland 23a or 28a-f show any notified at once.	5	121 Danford Dr	ive			21921			USA			
death with tritems 23s	1	Marital Status     Never Married 2 Ma	12. Was Decede Armed Force	s?			spanic Origin? ( Sp n, Mexican, Puerto					
ter dea	-		1 Yes orced If Yes, Give Year	2 X No	1 \	res 2 X No	specify:		Speci	fy:	White	
atural"	ઽ⊢	15. Decedent's Education (Spec	or Dates:	ompleted)			tion (Give kind of w		16b. Kind of	Business/	Industry	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exam		Elementary/Secondary (0-12)	College (1-4 o	r 5+)			., , , , , , , , , , , , , , , , , , ,		D.t.	ail 17	urniture	
-003 4 withi giene. ther the	<u> </u>	10 7. Father's Name (First, Middle,	Last)		Labo	rer	18.Mother's Name	(First, Middle,			urniture	
215 be file mal Hy rked o ent, th		Paul D. Childe						. Riden	- :=			
MD 21215-0036 d 2 should be filed within 7 this and Mental Hygien at 27 is marked other than turnatic event, the Medical TO Be Comple	- 1	9a. Informant's Name/Relations			1		et and Number or F				e, Zip Code)	
, ME and 2 s ealth a em 27	- 1	Tina L. Frank1:	in/Mother_		Place of Disposit		emetery,	g Sun,	20c. Locati	on - City o	r Town, State	
iore it of H	- 1	1 Burial 2 X Cremation		State	crematory or othe			3-2007	Diei	C.	- Marriland	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once To Re Compulated by Furneral Director		Donation 5 Other Set 1. Signature of Funeral Service	cecify:	<u></u>		aruner ame and Addres					n, Maryland Home, P.A.	
Per Per Per Per Per Per Per Per Per Per		Kuchard	y do	die	11	1 S. Qu	een Stree	et. Ris	ing Su	n. MD	21911	
Physician /Medical	2	23a. Partil. Enter the disease, or failure. List only one cause	on each lige	/				r respiratory ari	rest, shock, or	heart	Approximate Interval Between Onset and Death	
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	-	Sequentially list conditions,	b		·/·							
		f any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence o	f):							
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60, ate be ex hysician le burial	ğ	Y UNPENDED	#23a,27,		perME,g86	9 <b>,</b> 7/13/0	07 TT		23d. Dat	e of delive	ry	
Sox 6876/ death certificate e attending phy for use as the b		3b. Was decedent pregnant in the past 12 months?	he 1 Live birth		2 Fet	al death 3	Ectopic pregna	ancy	Mont	th	Day Year	
Box 687 death certific the attending p	ᇙ	1 Yes 2 No 9 Un	7	at time of de	eath 5 Oth	er (Specify)						
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ords w requests been should	Completed							24a. Was			autopsy findings available completion of cause of	
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or Att or Att or Att or Att or Object in by i	<u>≅</u>	3 Suicide 6 X Cou	28e. Place o	f Injury - At h	nome, farm, stree		building, etc.	or Town	State)		Rural Route Number, City	
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To with	ĕŀ	29b. Signature and title of certifi	and manner state er	ed	<del></del>	29c. Licer	nse number		29d. Date	signed (N	fonth, Day, Year)	
		aue IZ	^			0.0	<b>.</b> M.E.		June 28	3, 2007		
		30. Name and address of perso			m 23a)	troot D-IF-	are MD 0400	11				
0			sistant Medical Ex			treet, Baltin	nore, MD 2120					
Sta Registr	te ar	31. Date filed (Month) Day, Year,	6 2007 32.19	trar's Signat	Is high							

State of Maryland / Department of Health and Mental Hygiene

		•	1 = For State Registrar	,	Cer	tifica	ate of L	Death		Re	g. No. 2	1111	22,2	1	
	División de la constante de la		1. Decedent's Name (First, Middle, La	st)						ate of Death	n Day	Year	3. Time of Death		
190	Physicia /Medic		ROSEMARIE	MITZI	CROWLEY				JÜ		1	2007	8:10 A M		
	Examin	4	4a. Facility Name (If not institution, giv			4b. Cit	ty, Town, or	Location of De	eath		4c. Coun	ty of Death			
			St. Mary's Hosp				eonard				5	St. Ma			
	Funeral		Social Security Number     6. S	□M 25€F	s. last birthday) Yrs.	Month	er 1 Year s Days		fin. (A	ate of Birth flonth, Day,		Cou			
	Director	-	213-78-6034 Usual Residence of Decedent	47	110.				Ma	y 17,	1960	Mary	land		
	and t	ŀ	10a. State 10b. County	10c. C	City, Town or Lo	cation							10d. Inside City Limits		
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	ns 2; mus	Funeral	11, Marital Status	12. Was Decedent Ever in	U.S. 13.	Nas Dec		ispanic Origin? un, Mexican, Pe	(Specify Y	es or No-	14. R	ace - Ameri			
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<u> </u>	2 should be filed within 72 hours after death with the Maryland and Mertal Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ပ္	Edward D.	Hilbert				Judi			Koı				
Maryland 21215-0036	2sh and ism raum		19a. Informant's Name/Relationship ( Arden J. Keck, J	**	I	•	•	and Number of <b>Iill Ln</b>					•		
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altimore,	it. Part rtant rtant njury	Ì	4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	,,	rinsfie				3/200				Mall, MD	-	
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σ.	s that ned b		Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlyin	g cause giv	en in Part I.	2	23e. Did tob	acco use co	ntribute to	the cause of death?		
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ပ္ပ	s bee	Completed							2	24a. Was ar		b. Were aut	opsy findings available		
æ	The lay te has age 2	E							_	autops perforn I□ Yes 2	y ned? 2.⊡•No	death?	ompletion of cause of		
ţ		BeC	25. Was case referred to medical					26. Place of							
>	Attending Physician: r death. ector: After this certific: by the funeral director,	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3□	DOA Oth	er: 4 □ Nursir	ng Home	5 ☐ Reside	nce 6 🗆 C	ther (Spec	ify)		
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f	28c. Injur Wor	y at k?	28d. I	Describe ho	w injury occ	urred			
<u>0</u>	endir ath. or: At	aţic	2 ☐ Accident investigation			М		Yes 2 □ No							
Division or Vital Records,	or Atten after deatl Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, str cify)	eet, fact	tory, office			ocation (State) City or Town		mber or Rui	ral Route Number,		
	ospital or Atten hours after deatl neral Director; ly filled in by the			To be a second	manufacture de la	h aa	and nat the city								
	Hos Fun rely	ledical		nysician: To the best of my k miner: On the basis of exam and manner stated.										١,	
	To the within 2 To the complete	Me	29b. Signature and title of certifier				29c. Licens			2	9d. Date sig				
			14 (me		MD		D	56095	in the same		7-	1-07	7		
			30. Name and address of person who	completed cause of death (It	tem 23a) (Type,	Print)									
			DR. RAJBINDER GI	LL PO BOX 640  32. Registrar's Sig	HOLLYW	OOD	MARYI	AND 20	636						
			<ol> <li>Date filed (Month, Day, Year)</li> </ol>												

ROSEMARIE CROWLEY

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** GORDON K. CALVERT JUNE 2007 12:20AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WILLIAM HILL MANOR EASTON TALBOT 8. Date of Birth (Month, Day, Year) FEB. 23, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 95 Yrs. Director PA 171-07-9607 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 is marked other then "neturel", or Items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1√2 Yes 2 □ No Director MDTALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 516 TRIPPE AVE. 21601 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ Specify: WHITE 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) s 1 and 2 should be filed within f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER FROZEN FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STANLEY CALVERT MARGARET KEIRN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GORDON K. CALVERT, JR./SON 5072 REED ROAD, OXFORD, MD 21654 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. ^ 4 ☐ Donation 5 ☐ Other (Specify) 6/21/2007 OXFORD, MD OXFORD CEMETERY 22. Name and Address of Far FELLOWS, HEL 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 MERCERON 10HN ス, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ples Seemes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical as 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy should be detached for Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 hustras Work 1 Yes 2 No 3 Probably 4 Unknown Completed .24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an rmed?/ 2☐No certificate In Thy 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case ref a examiner? d to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 2 : After this funeral o 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Momicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Klam 30. Name and address of person who completed cause of death (Item (234) (Type, Print) 15 + VA WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Regitrar's Signature State JUN 1 9 2007 Registrar

· Vital Record	The law requ
or Vital	
ivision or	l or Attending Physician:
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		_	Pleas	e Type or Prir State of Ma			delible Inka			-		gible.			
•		1 - For State Registrar				-	rtificate of		Reg. No. 2007 22431						
Physic	ian	1. Decedent's Name					2. Date of Death Month Day Year  3. Time of Death								
/Med		4- 5-7-17-11-46		Carroll	Lee	Canfi		1	(D1)	July	5	2007	0945 AM		
Exami	ner			give street and number) nty Hospita.	7		4b. City, Town, o	r Location gers t		1	4c. Cour	nty of Death <i>Washii</i>	naton		
Funeral		5. Social Security Nu		6. Sex 7. Ag		ast birthday)			der 24 Hrs.	8. Date of Birt (Month, Day	/. Year)	9. Birthp	lace (State or Foreign		
Director		217-30-6239 TAIN 20 7 71 Yrs. J.						Jan. 10	n. 10, 1936 Maryland						
yland Iow at		10a. State	Usual Residence of Decedent  10a. State 10b. County 10c. Cit				ocation		-			10d. Inside Cit			
e Mar sa-f sh tiffed	ctor	Maryland Washington Keed					eedysvill	le				1 ☐ Yes 2 ☐ No			
5-UU30 72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	Director	10e. Street and Number           5534 Porterstown Road           11. Marital Status         12. Was Decedent Ever in U.S.					10f. Zip Code	756			10g. Citizen of What Country?				
leath v ns 23a must	Funeral					3. 13.	Was Decedent of H If Yes, specify Cub		Origin? (Spe	ecify Yes or No-	. 14. F	U.S.Z			
after or Item	표	Armed Forces?  1 □ Never Married 2 Married 1 □ Yes 2 Myo If Yes, Give			No		If Yes, specify Cub  1 ☐ Yes 2 X No			Rićan, etc.)		Black, White,	etc.		
2-UCSO 72 hours af natural", or lical Exam	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					-	·	ary.	Specify:			nite		
in 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)				16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retire	pation : <i>during n</i> :d)	nost of worki	ing	16b. Kind of	Business/In	dustry		
d with giene. rr thar	Ę,	Elementary/Secon	ndary (0-12)	College (1-4or 5	5+)		Mechanic			I		Auto	motive		
be file tal Hy d othe	Be	17. Father's Name (	First, Middle, La	ast)				18. Mo		(First, Middle,		name)			
hould d Men narke	은	Herbert L. Canfield  19a. Informant's Name/Relationship (Type. Print)				Freda  19b. Mailing Address (Street and Number or Rura)				G. Cli		um Ctota Zin	Codel		
IOTC*, INIATYIATIG ZIZIS-UUSO  ges 1 and 2 should be filed within 72 hours after death with the Marylan  tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Linda L.	,				Porterst						<i>*</i>		
of Hea		20a. Method of Disp	osition		20b. Pl	ace of Disp	osition (Name of ematory or other pla		; -	Date		n - City or To			
DallIIIIOre permit. Pages 1 Department of H Important: if ite any Injury or ot once.		1 ☐ Burial 2 ½ 4 ☐ Donation	_	3 □Removal from State ecify)	- 1		rg Cremat		20	y 6, 07	Smiths	burg,	Maryland		
Dall permit. Depart Import any Inj once.		21. Signature of Fur	neral Service Li	icensee	10141	•	2. Name and Addre		-	J.L. D					
		23a Part1 Fr ar th	disease or o	complications that caused	the death		2525 Brad					Maryla	Approximate		
Physician		shock, or heart failure. List only one cause on ach line.  Immediate Cause (Final disease or condition resulting in death)  a										Interval Between			
/Medical Examiner		Due to (or as a consequence of):  Congestivity Haard - Perleuce													
Tagas,	je.	Sequentially list con if any, leading to fine cause. Enter Under Cause (Disease or i	a nonsequ	ence of):	11 -										
executed executed in and ial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) L	A-												
be ex		,		Due to (or as	a consequ	ence or):									
certificate ding physise as the l	edic			d											
ath cert	an/M	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1□Live birth			□Ectopic pregnanc	ev				23d. Date of delivery			
- 6 6 T	Physician/Medical	in the past 12 months?  1								Month Day Year					
s that ined by e deta	by Ph									23e. Did t	tobacco use contribute to the cause of death?				
ecords, law requires t as been signe 2 should be o										10	Yes 2□ No	o 3□ Prol	bably 4 Honknown		
II RECORDS, P.O. The law requires that the sate has been signed by the page 2 should be detached.	Completed							_		24a. Was autor perfo 1∐ Yes		lb. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of 2 No		
VITAL SICIAN: T certificat rector, pa	Be	25. Was case referr examiner? 1 ☐ Yes 2		Hospital:			Otl	hom		h (Check only o					
g Physer this eral di	n: To	27. Manner of Death	1	28a. Date of Inju	ıry	28b. Time	0	4		me 5 Resi			fy)		
Attending at death.	atio	1 ☐ Natural 2 ☐ Accident	5 Pending investiga	ation	y rear)	Injury		Yes 2	2 □ No						
LINIS  tal or Att rs after de ral Direct ed in by	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin		ury - At ho c. (Specify	me, farm, s	treet, factory, office			28f. Location (S City or Too		ımber or Run	al Route Number,		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 v.	edical	29a. Certifier (Check only one)	1  Certifying 2  Medical E	Physician: To the best xaminer: On the basis of and manner st	of examinat	wledge, dea ion and/or i	th occurred at the t nvestigation, in my	time, date opinion,	e and place, death occur	and due to the red at the time,	cause(s) and date and pla	I manner as s ce, and due t	stated. to the cause(s)		
To 1 To 1	Z	29b. Signature and	title of certifier	Inhang.	end		29c. Licen:	216	157		29d. Date sig	-200	7		
		30. Name and addre	ess of person w	no completed cause of c	128	23a) (Type	Print)	Ave	e HA	GERSE	INV.	MD	21742		
S Regis	tate trar	31. Date filed (Mont	th, Day, Year)	32. Registr	rar's Signat	And	7								
DHMH 17 Rev 1	/2004		F 45	3		1									

		,	1 - State Registrar		partment of Health and N <i>Certificate of Death</i>	lental Hygie/ Reg.		22431			
1	Physicia	20	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death			
	/Medic		Agnes Marie Dick				30 2007 5:10 AM				
	Examin	er	4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death		4c. County of Death				
÷	Funeral		Washington County Ho 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	Ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Washington  9. Birthplace (State or Fore Country)				
	Director		217-12-2931 1 M 2X	82 Yrs	Months Days Hours Min.			ary land			
	and w t		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits			
	Maryl -fsho fieda	tor	Maryland Washingto	ın.	Williamsport			1 ☐ Yes 2√XNo			
	th the or 28a e noti	)irec	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Cour	ntry?			
	ath wi	Funeral Director	428 S. Artizan Stree		21795		USA				
	ter de items ner m	-une	Arme	Decedent Ever in U.S. I Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,				
	urs aft al", or Exami	by	3√Widowed 4 Divorced Year	es ACXNo Give or Dates:	1 ☐ Yes XX No Specify:		Specify:	White			
5	72 ho 'natur dical I	Completed	15. Decedent's Education (Specify only highest grade complete	16a. De	ecedent's Usual Occupation live kind of work done during most of work ie. DO NOT use retired)	ring 16t	b. Kind of Business/In	dustry			
7	within ene. than "	ldu		e (1-4or 5+)			Home	2			
7	filed v Hygic Sther i	ပ္ပ	17. Father's Name ( <i>First, Middle, Last</i> )		Housewife 18. Mother's Nam	e (First, Middle, Mai	Home iden Surname)	3			
0	ald be dental rked o	To Be	John William Obitt	's	Marv	sabelle	Shives				
a	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street and Number or Ru			<b>,</b>			
<u>≥</u> נו	1 and 2 Health em 27 i		Ellis E. Dick - Son  20a. Method of Disposition		S. Artizan St. Wil		c. Location - City or To				
2	permit. Pages 1 and 2 Department of Health e Important: If Item 27 is any Injury or other tra		1 🛱 Burial 2 □ Cremation 3 □ Removal fi 4 □ Donation 5 □ Other (Specify)	om state	crematory or other place)		,				
	mit. Foartme		21. Signature of Furieral Service Licensee		wn Mem. Park July ଫେଟେମଟ™ Artunerativ Hon		illiamspor	<del>т,ма<b>r</b>yland</del> 21795			
ă	permi Depa Impo any Ir once,		Duttelsh		425 S. Conococheagu		lliamsport	, Maryland			
			23a. Part. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death. Do not on each line.		or respiratory arrest		Approximate Interval Between Onset and Death			
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	Examiner		$\blacksquare$ $\square$ $\square$	to (or as a consequence of):							
L	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	to (or as a consequence of):			-				
	ecuted and -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due	to (or as a consequence of):							
00/00	ficate be executed physician and s the burial-transit			to (or as a somequence or).							
000	tificate g phys	ledical	d								
2	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M		outcome pf pregnancy ve birth 2  Fetal death	3 ☐ Ectopic pregnancy	23d. Date of deliv	rery Day Year				
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ŗ	that the ed by detac		Part II. Other significant conditions contributing	co use contribute to the cause of death?							
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2	law re as bee 2 sho	plete				24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of			
	The cate has page	Completed				performe	d? death? 1 No 1 ☐ Yes	2 □ No			
7	sician: The law s certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?	1	Other	th (Check only one)					
5	y Physer this eral di	: To	27. Manner of Death 28a. D	ate of Injury 28b. Tim	ne of 28c. Injury at		5 ☐ Residence 6 ☐ Other (Specify)  Describe how injury occurred				
5	arth. or: Afte	atior	2 Accident investigation	Month, Day Year) Inju	ry Work?  M 1 □ Yes 2 □ No						
2	or Atterder terde iirecton by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	lace of injury - At home, farm uilding, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,			
2	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Medical	(Check only 2 Medical Examiner: On t		or investigation, in my opinion, death occu						
	To th withir To th comp	Me	29b. Signature and title of certifier	In	29c. License number	29d.	Date signed (Month,	Day, Year)			
)			James .		7060396		06/20/	1			
_	5H-4		30. Name and address of person who completed	cause of death (Item 23a) (Ty	pe, Print) 1126 07	stour	MD 2	1740			
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 2 2007	2. Registrar's Signature	Sperks	,		. 1			
					1						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Certifi	cate of	Death		Reg. No	الالالكان	• 10 10 10	104
	3 ×	111	1. Decedent's Name (First, Middle, Last,						2. Date of De	eath Da	. V	3. Time of	f Death
Н	Physici /Medi		Mary Anne Duffy								9.007 Year	9:30	P M
į.	Examir		4a. Facility Name (If not institution, give		4b.	City, Town, o	Location of Death			. County of Death			
			Anne Arundel Medic	al Center	•	A.	nnapol:	is		An	ne Arund	le1	
	Funeral		5. Social Security Number 6. Sec		e (In yrs. last birth	nday) If I	Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Birth	place (State	or Foreign
:	Director		578-22 <b>-</b> 0875	]M 2[X]F	82 Y	rs.	onths Days	Hours Min.			924 Wash		DC
	TO .		Usual Residence of Decedent		1								
	how at		10a. State 10b. County		10c. City, Town	or Locatio	n					10d. Inside C	•
	a-f s	cto	Maryland Prince G	eorge's	Bowie							<b>X</b> Yes	2 □ No
	or 28	Director	10e. Street and Number			10	0f. Zip Code			10g. Cit	izen of What Cou	ntry?	
	th wit	a	12405 Westmore Cou	rt		2	0715			USA			
	be filed within 72 hours after death with the Maryland ital Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S.	13. Was	Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	o-	14. Race - Americ Black, White.		
9	after or Ite		1 ☐ Never Married 2 Married	1 ☐ Yes 2 X I	No		res 2X No	Specify:	riioan, oto.,			etc.	
03	ral",	l by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			22110	opeary.			Specify: Whi	te	
21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. I	Decedent's	s Usual Occup	ation during most of work	ina	16b. K	ind of Business/In	dustry	
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	filed wi Hygien Ither th	ပ္ပြ	12		Pro	cure	ment Co	ntractor			ional Gu	ard	
p	al Hy	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle	, Maiden	Surname)		
/la	should be to made the find Mental I is marked or umatic ever	은	Willis Booth					Lessie S	wann				
Maryland	and and sum		19a. Informant's Name/Relationship (Ty	pe. Print)	19b.	Mailing Ad	ldress (Street	and Number or Rui	al Route Numb	er, City	or Town, State, Zip	Code)	
	rtr		Robert Duffy/ Husb	and	124	105 W	estmore	e Court B	owie, M	D 20	715		
<u>S</u>	of Hec		20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ F		20b. Place of i	Disposition , cremator	n (Name of ry or other plac	ce)	Date	20c. L	ocation - City or T	own, State	
Ĕ	Pages nent of int: If its iry or o		4 Donation 5 Other (Specify)		Fort Li	incol:	n Cemet	ery 6/28	/2007	Bre	ntwood,	MD	
Baltimore,	+ 등 다 는		21. Signature of Funeral Service Licens	ee	1			ss of Facility Ro					ne
Ö	Depar Impo any Ir		/LIAU			1		apolis Ro					
6			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused	the death. Do no	ot enter the	e mode of dyir	g, such as cardiac	or respiratory a	ırrest,		Approximat Interval Bet	te tween
	Physician		Immediate Cause (Final	Par	000011							Onset and	Death
100	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of	Ti:							
	Examiner			Dimi	1hia	900					1,	101/0	0.10
		ē	Sequentially list conditions, if any, leading to immediate cause. Liner Undenying Cause (Disease or injury	Due to (or as	a consequence of	f):						JAKA	Jul
	uted	Examine	Cause (Disease or injury that initiated events										
-,	al-tra	xa	resulting in death) Last	Due to (or as	a consequence of	f):							
68760,	certificate be executed ding physician and se as the burial-transit	2											
687	ficate phy s the	/Medical											
×			IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	pf pregnancy						23d. Date of deliv	erv	
Bo	eath atter for u	ciar	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 ☐ Fetal death		opic pregnancy ner <i>(specify)</i>	′			Month		Year
P.O.	at the de by the a stached i	Physiciar	1 □ Yes 2 ☑ No 9 □ Unknown	9□Unknown			()/						
	res that igned by		Part II. Other significant conditions co	ntributing to death b	ut not resulting in	the underly	ying cause giv	en in Part I.	23e. Did	tobacco	use contribute to t	he cause of o	death?
ds	sign d be	1 by	Dehudration						10	Yes 2	□ No 3 □ Pro	Probably 4 Onknown	
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/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11-1			Lau	26. Place of Deat	h (Check only	one)			
or \	dii jys	ပ္	To res 2	lospital: 1 Mipatie			□ DOA Oth	4 □ Nursing Ho	ome 5 Resi	idence	6 □Other (Speci	fy)	
2	ng fter	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Ti <i>y Year)</i> Inj	me of jury	28c. Injur Wor	y at k?	28d. Describe	how inju	ry occurred		
Sio	tendi eath. or: A	ati	2 Accident investigation			V	1 1 🗆	Yes 2 □ No					
Division	I or Attendiation after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju- building, et	ury - At home, farr c. <i>(Specify)</i>	m, street, f	actory, office		28f. Location ( City or To	Street ar	nd Number or Run e)	al Route Nun	nber,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best	of my knowledge, f examination and	death occ	curred at the tirgation, in my o	ne, date and place,	and due to the	cause(s	) and manner as s	stated.	s)
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier				29c. Licens	~		29d. Da	te signed (Month,	Day, Year)	
	11-11		* KOSOV				D6	4481		06	123/07		
	Oak		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (T	ype, Print	)				1		
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 2 6 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:56 рм Merlin J. Daste June 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 3160 Gracefield Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 № M 2 □ F Yrs. Director 436-24-8194 89 May 6, 1918 Louisiana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2k No Director Silver Spring Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3160 Gracefield Road U.S.A. Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify. 3 X Widowed 4 ☐ Divorced WWTT White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Interstate Commerce 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Ferrand 2 Ralph J. Daste 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Funk, Jr. - Personal Rep 1814 Stonegate Avenue, Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify, Gate of Heaven Cemetery 6/28/2007 Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy pertorm After this certificate 1∏ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 24-093 of death (Item 23a) (Type, Print)

3/10 GRACEFIEW SIWAR SARING, MD. 2090 4

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:20PM BENJAMIN DiDONATO JR. July 2007 /Medical 7. Age (In yrs. last birthday) Months Days Hours Min. 9/20/1 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 105 St. Marys Road Harford 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**X**M 2□F Maryland 217-40-7228 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or items 23s or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Pylesville Harford MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 St. Marys Road 21132 United States 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed withir Department of Health and Mental Hygiene important: if item 27 ie marked other then eny injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Machinist 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Epifanio Benjamin DiDonato Anna Russe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura DiDonato (Wife) 105 St. Marys Rd. Pylesville, MD. 21132 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Marys Cemetery 7/7/2007 Pylesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) St. 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A Approximate
Interval Between
Onset and Death
6 manths 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Esophageal concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attanding physicien and hed for use as the burial-translt Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Triknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate hes 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending R within 24 hours aftar death. To the Funerel Director: After Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058475 2007 JULY 5

Registrar

Boardes

PHILIP NIVATPUNIN, 602 SOUTH ATWOOD ROAD, BIZL AIR MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 20 7 **Physician** Betty Lou Earnhardt jur 2:24 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown
If Under 1 Year | If Under 24 Hrs. St. Mary's 8. Date of Birth
(Month, Day, Year)
January 6, 5. Social Security Number 7. Age (In vrs. last birthday) (State or Foreign **Funeral** Days Country) West Virginia Months Hours 1 ☐ M 2 👿 F 579-70-1507 58 Yrs. 1949 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Maryland St. Mary's Mechanicsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27651 Valley Wood Ct. 20659 A 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John P. Kirby Burtrice Boone ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Stephens Son 27651 Valley Wood Ct., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Brinsfield-Echols Crem. 7/3/2007 Charlotte Hall,MD 22. Name and Address of Facility Brinsfield-Echols Funeral Home, 21. Signature of Funeral Service Licensee M00641 P.A., 30195 Three Notch Rd., Charlotte Hall, MD20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Minutes **Physician** /Medical Due to (or as a consequence of): me 14 nome 1795. Examiner metastahc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of) Physician/Medical Box ( 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No ≥X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Medical Certification: To ₽ 28a. Date of Injury (Month, Day Year) 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhananjay Bhavsar Hollywood, MD 20636 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Orville N 4:00 P.M June 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Smithsburg 22903 Civic Circle 8. Date of Birth (Month, Day, Year) May 31, 1925 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Maryland 216-76-1978 82 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD Washington Smithsburg 1 X Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22903 Civic Circle 21783 USA filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 18 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) Coltege (1-4or 5+) Hygiene. Handicapped Handicapped 0 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o Orville Norris Friend, Sr. Elma Fike 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 Florida Ave., Hagerstown, MD 21740 ARC of Washington County 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Steele Cemetery July 1, 2007 Friendsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Newman Funeral Homes, P.A., P.O. Box 275 any in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he intradiure. List only one cause on each line. elion Approximate Interval Between Onset and Death Immediate Caus (final disease or condition resulting in death) triclore Due to (or as a consequence of). Physician /Medical Examiner heart disease athen oscleration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending I for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? 1 Yes 2.☑No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760. within 24 hours a

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Jefferson Soham 22981 Brian 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

np

29b. Signature and title of certifie

Baulevard

29c. License number

0054451

29d. Date signed (Month, Day, Year)

June 28.

			For State	State of Maryland				al Hygiene	2007	22437
			Registrar	···	Cer	tificate of Dea		Reg. No	١.	
	Physici		1. Decedent's Name (First, Middle, Last)  JUSE Phine	Eleano	V-	Fike	N	ate of Death Jonth Da	y Year . 200 7	3. Time of Death  10: 30 A M
	/Medio		4a. Facility Name (If not institution, give s		<u></u>	4b. City, Town, or Locati			. County of Death	
	_ Kaiiiii		Kontry Kom For	rt Assisted	Living	triands	ville	(	farre	++-
F	uneral		Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year If Un Months Days Hou	der 24 Hrs. 8. D	ate of Birth Month, Day, Year)	9. Birth	aplace (State or Foreign
	irector		218-16-3484	<sup>M 2</sup> (X) <sup>F</sup> 90	Yrs.	Months Days Hou	Au	g. 28, 1	916 Mar	yland
5	<b>2</b> 5-2		Usual Residence of Decedent  10a, State 10b, County	100 City	Town or Loc	ation				10d. Inside City Limits
laryla	sho a	2								1 ☐ Yes 2 ☐ No
he N	r 28a-f show	Director	MD Garrett  10e. Street and Number	Fri	endsv	10f. Zip Code		10- 04	Nin 6 14/h - 1 C	
with	De								tizen of What Cou	
eath	10 23	era	1466 Dixon Road	2. Was Decedent Ever in U.S.	13 W	21531	Origin? (Specify )		ted Stat	
fterd	T He	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No	lf.	as Decedent of Hispanic Yes, specify Cuban, Mex	ican, Puerto Rican	n, etc.)	Black, White	
<b>-UU35</b> hours after death with the Maryland	9,1	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐Yes 2XX No Spec	city:		Specify: Wh	ite
2 P	"naturel", or iteme 23a or solder Examiner must be	Completed	15. Decedent's Educ	ation	16a. Decede	ent's Usual Occupation	most of working	16b. K	ind of Business/I	
ZTZT5-0036 d within 72 hours af	r than "natu the Mudical	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	lite. D	ind of work done during n O NOT use retired)	nost of working			
		S	12		Farı	ner & Homema			)wn Home	
	ed other	Be	17. Father's Name (First, Middle, Last)			18. M	other's Name (Firs	t, Middle, Maiden	Sumame)	
aryia should	Marke Maric	၉	Clarence Fike				aura Humb			
2 0 0	ra mar		19a. Informant's Name/Relationship (Typ			Address (Street and Nu		· ·		
<b>a</b>	Item 27 is marke other traumatic		Mr. Carol Burkhard  20a. Method of Disposition			S. Pleasant Ition (Name of	Valley R		minster;	
Pages	= 0		tX Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	netery, crem	atory or other place)	1		,	
altimore,	ntani		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			Cemetery	17/6/07	_	endsvill	le, MD
Dermit.	important: If its eny injury or or once.		Wastle M.			Name and Address of Fa David A. Bur				
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death.	Do not ente	21 N. Second rithe mode of dying, such	as cardiac or resp	KLand, M.  Diratory arrest,	ш 21550	Approximate
Dho	, cicion		shock, or heart failure. List only on Immediate Cause (Final	- 1	A.	<b>\</b>	and the same of th	,		Interval Between Onset and Death
	/sician ledical		disease or condition resulting in death)	De menti		lzheimers	190.2			2 years
Exa	aminer			(0 (0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 -						
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nee of).					
cuted	nd ransi	Examiner	that initiated events C.							
Š. Š.	urial-		resulting in death) Last	Due to (or as a conseque	ince of):					
. BOX 68/6U, death certificate be execut	physician and the burial-transit	dicai	d			****				-
Sertific O	centificate has been signed by the attending prector, page 2 should be detached for use as	/Mec	IF FEMALE:	to If you cutoome of programs						
DOX	attend for us	lan	in the past 12 months?	bc. If yes, outcome of pregnand t Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3 □	Ectopic pregnancy			23d. Date of deliver Month	very Day Year
) §	ched	hysician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	m, 20	Other (specify)				
r Ē	deta	۵.	Part II. Other significant conditions con	ributing to death but not result	ing in the un	derlying cause given in Pa	art I. 2	23e. Did tobacco i	use contribute to	the cause of death?
RECORDS, P.O.	n sign	d by	mitral	regurgito	tron.			1 🗌 Yes 2	DKNo 3 □ Pro	bably 4 Dunknown
ecol	shou	lete					2	4a. Was an	24b. Were auf	opsy findings available
	age 2	ompleted						autopsy performed? ☐ Yes 2 2 No	nrior to c	ompletion of cause of
	this certificete ha al director, page	O	25. Was case referred to medical			26. P	lace of Death (Che		1 Yes	2 No
	is cer direc	To B	examiner? 1 Tes 2 No	ospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient	Other	Nursing Home	7/27	6 XOther (Spec	
o e	ter th		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?		Describe how inju-		1
	or: A	atic	2 Accident investigation			M 1 ☐ Yes 2	2□No			
JIVISION or Attending	irect n by 1	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office "	28f. Lc	ocation (Street ar City or Town, State	nd Number or Rui 3)	ral Route Number,
Dital c	lled :		00-0-4							
Hosi	To the Funeral Director: After this completely filled in by the funeral director.	edical	29a. Certifier 1 Cartifying Phys (Check Only 2 Medical Examin	ician: To the best of my knowler: On the basis or examination and manner stated.	edge, death in and/or inve	occurred at the time, date estigation, in my opinion,	e and place, and di death occurred at	ue to the cause(s) the time, date and	and manner as diplace, and due	stated. to the cause(s)
o the	o the	Me	29b. Signature and title of certifier	and married dialog.		29c. License numb			te signed (Month	
<b>⊢</b> 3	: ⊢ ö		· MALL	Men -	M	D. D.00	2575			
			30. Name and address of perspn who cor	npleted cause of death (Item 2	3a) (Type, P	Print)		1 24	1 -1-	
		3	walter K. Na	umannMD	POB	D. D.O.O. ;	Accident	+ MD	21520	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		9 - 05 -				
	Registr	ar	JUL - 5 20	JUI A STATE OF						

07-04562									
Randv	Forrest								

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Medical Examiner 1530 hrs June 14, 2007 Forrest 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Washington Months Director Davs Hours Min 220-92-0365 October 9,1963 ▼M 2 Country) Usual Residence of Decedent in 10a, State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ust be notified at once. 1 Yes 2 X No MD Prince Georges Forestville Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7420 Marlboro Pike 20747 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Armed Forces' White, etc. Married Yes 4 Divorced If Yes, Give Year Yes 2 X No specify: Widowed White 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Baltimore, MD 21215-0036 Installer Fenceing 17. Father's Name (First, Middle, Last) 8.Mother's Name (First, Middle, Maiden Surname) Randolph Lee Forrest Dorothy Smith 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Forrest/Mother 926 Truro Lane, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State tant: If it crematory or other place) Burial 2 X Cremation 3 Department of Brinsfield-Echols Crem. 6/25/07 Charlotte Hall, MD Other Specify: Donation 5 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. M00945 de 20646 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medica Death Complications of Choking on Food Bolus Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

4 hours after death.

4 hours after death.

4 hours after death.

4 hours after death.

5 hours after death.

6 hours after this certificate has been signed by the attending physician and after filled in by the funeral director, page 2 should be deached for use as the burial - transit entered. Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 1 🗸 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 Yes No 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jun 11, 2007 Choked on food bolus 1 Natural UNKNOWN Yes 2 V No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 7420 Marlboro Pike, Forestville, MD determined (Specify) Nursing Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 15, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar DHMH 17 Rev 1/2001

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend PI(23a-b), 27,28a-f, perME, C870 C871 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 10:00 P M Idonia Christine Green July 2007 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4c. County of Death 20178 Piney Point Road St. Mary's Callaway If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 218-56-0676 Director July 8, 1951 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Director 1 ☐Yes 2 No Callaway Marvland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20620 Funeral 20178 Piney Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐ Yes 2 ⅓ No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Support Administrator State Government 12 Pages 1 and 2 should be filed then tof Health and Mental Hygicint: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Lawrence Thomas Leroy Maddox, Sr. ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai Joseph Emil Green / Husband 20178 Piney Point Road Callaway, MD 20620 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethesda United 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July 7, 2007 Valley Lee, Maryland 4 Donation 5 Other (Specify) Methodist Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Ilypertensive atherosclerotic cardiovascular discussionset and Death 23a. Part1. Enter the disease, or complications that cans shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Neon 3 Sulcide 1 ☐ Yes -2 1 07 2200 Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours aft To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifie

25365 Pt. Lookout Road

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 0 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd II, M.D.

Leonardtown, MD 20650

29c. License number

29d. Date signed (Month, Day, Year) 7-3-07

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Harry Vincent GRABILL 2007 8:15 a.M July 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Homewood At Williamsport Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 X M 2 □ F 228-18-6074 88 Director 5, 1918 Nov. West Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits Maryland Washington Director Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or; any Injury or other traumatic event, the Medical Examiner must be none. 18310 Summerlin Drive 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: white þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) linotype operator gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Grabil1 ပ္ Nora Ropp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy M. Grabill - wife 18310 Summerlin Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Hagerstown, Maryland 21. Signature of Funeral Service Lice Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician be Physician/Medical as the k nse i IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy 2 No Hospital or Attending Physician: Was case referred to medical examiner? Be 26. Place of Death Check onl one) 1 Tes 2No Other: 2 ER/Outpatient 3 DOA 2 1 ☐ Inpatient 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending (Month, Day 1 Natural 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 4:50 p<sup>M</sup> Virginia Estelle Gathman /Medical 19 2007 June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 712 Dill Road Anne Arundel Severna Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 64 216-42-1762 Director Nov. 06, 1942 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 Dill Road 21146 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛛 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia MacKnew James Cumberland Pages 1 and 2 should or other traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 712 Dill Road, Severna Park, Maryland 21146 George F. Gathman/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) June 25 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Metro Crematory Baltimore City, MD 4 □ Donation 5 □ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Euneral Service Licenses 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy į in the past 12 months2 1 ☐ Yes 2 ☐ NO Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) Certification: To 1 🗌 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) this Mann 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 After Hospital or Attending after death Director; filled in by the

Maryland 21215-0036

Baltimore,

within 24 hours a To the Funeral L Medical

29b. Signature and title of certifier

6 ☐ Could not be

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Mont)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 53306

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

manner stated.

Curtos

EUU Bestsote Rd Stezuo Annapolis MD Year) JUN 2 6 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Harry Paul Elmer Galentine, Jr. June 21, 2007 /Medical 5:45 P. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11901 Grady's Court Rowie Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 ☑ M 2 □ F 215-36-3408 Director 67 1939 Washington, DC Aug. 6, Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20008 USA 2800 Woodley Road NW Apt. 532 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4X Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Commercial Leasing Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be file of Health and Mental His item 27 is marked oth Be Melvina Frances Sando ဂ Harry Paul Elmer Galentine, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Galentine/ Son 11901 Gradys Court Bowie, MD 20715 permit. Pages 1 a Department of Her Important: If item 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery crematorial other place) 1 ☐ Burial 2 🏖 Cremation 3 ☐ Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) 6/25/2007 Alexandria, VA Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licens 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-transit Exami and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9□Unknown 9 ☐ Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? Yes 2 XNo certificate 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Son ' 1 ☐ Yes 2 🗙 No Other: 4 Nursing Home 5 Residence Other (Specific Residence Hospital: 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA within 24 hours after use....

To the Funeral Director: After thi

manufetely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 33109 JUNE 25, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3800 RESERVOIR ROAD, Jimmy HUANG WASHINGTON DE 20007 31. Date filed (Month, Day, Year) State JUN 2 6 2007 Registrar

			1- State of Maryland / Dep	ertment of Health and Nertificate of Death		iene	22143	
	Physici	an	Decedent's Name (First, Middle, Last)  KAREN GRANT		2. Date of Death Month JUNE	19 2007 Pear	3. Time of Death 11:39 PM	
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	l	4c. County of Death	11.39 1	
			FT. WASHINGTON HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	FT. WASHINGTO	N 8. Date of Birth	PRINCE GEO	RGE S  lace (State or Foreign	
	Funeral Director		577-98-2948 1□M 2□X 39 Yrs.	Months Days Hours Min.	(Month, Day, JULY 9	Year) Cour	HINGTON.DC	
	ow .		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I.	ocation		1	0d. Inside City Limits	
	e Man	Director		HILL			1 Yes 2 No	
	and the man	Dire	10e. Street and Number 6551 BOCK ROAD	10f. Zip Code 20745	10	Og. Citizen of What Cour		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any rigury or other traumatic evant, the Medical Examinate for natified at ODGe.	by Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
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	nd 2 sh lith and 27 is m r traum			ling Address (Street and Number or Rur  BOCK RD OXON HIL			Code)	
Baltimore,	Pages 1 a nent of Hea ant: If item ury or otha		1 Buria 2 Cremation 3 Hemoval from State	ematory or other place)		20c. Location - City or To		
Balt	permit. Departi import any inj once.			22. Name and Address of Facility J 7474 LANDOVER ROAD		KINS FUNERA	L HOME 20785	
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,00	icate be executed physician and s the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c.  Due to (or as a consequence of):					
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.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year	
<b>_</b>	w requires that been signed by should be deta	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to the s 2 No 3 Prob		
Division of Vital Records,		Completed			24a. Was ar autops perform 1 \( \text{Yes} \) 2	prior to cor	psy findings available mpletion of cause of 2 No	
<u> </u>	ysiciar is certif directo	o Be	25. Was case referred to medical examiner?  1 X Yes 2 □ No Hospital: 1 □ Inpatient 2 X ER/Outpatie	Other	h <i>(Check only one</i> ome 5 ☐ Reside	nce 6 □Other (Specifi	y)	
o uoi	by the Hospital or Attending Physician: The fulful 24 hours after death.  • the Funaral Director: After this certificate his completely filled in by the funeral director, page	ation: T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  27 Accident Injury	of 28c. Injury at Work?  M 1 \( \text{Yes} \) 2 \( \text{No} \)	28d. Describe ho	w injury occurred		
DIVIS		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town			
	To the Hospital or Al within 24 hours after of To the Funaral Direct completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occur	red at the time, da	ite and place, and due to	the cause(s)	
1	4	Σ	29b. Signature and title of certifier	D 46 7 41		June 20,		
	Jo			Print) LIVINGSTON ROAD F	r. Washii	NGTON, MARYL	AND 20744	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 8 2007  Signature  32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24 24 JUNE 2007 7:30 P M GRIFFIN SR. **JAMES** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 5 GARRETT AVENUE **ARBUTUS** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV . 21 Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Year) 1913 Months Days Hours 1₽M 2□F MARYLAND Director 93 216-05-3491 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Yes 2 □ No Director BELTSVILLE MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 U.S.A. 5410 ODELL ROAD within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No BLACK Specify: þ 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If frem 27 is marked other the any injury or other traumatic exercises. MOTOR VEHICLE TRAINER GOVERNMENT 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDDIE GRIFFIN ALICE BARNETT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5 GARRETT AVENUE ARBUTUS, MARYLAND 21227 19a. Informant's Name/Relationship (Type. Print) JAMES GRIFFIN JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 7/3/2007 LAUREL, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician &/ay /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ue to (or as a consequence of): requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown signed I I be det Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ICER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an page 2 s autopsy performed? certificate 2 **X**No 1∐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SON'S HOME 1 XYes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation Hospital or Attending 1 XNatural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

cpmpletely State

31. Date filed (Month, Day, JUN 2 8 2007

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORBERTO MACHIRAN M.D.

TENDING

Registrar

KYSICIAN

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

720 MAIDEN CHOICE LANE # C CANTONSVILLE, MD

29d. Date signed (Month, Day, Year)

21228

December 11 Mary 1988 A 4 8 4 1 1	41		<u> </u>	rtificat	ie OI	Deam		1	Reg. N	ło.		
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5. Social Security Number 6. S	Sex 12∏ M 2□ F	7. Age (In yrs.		Months   Days   Hours   Min.   (Month, Day, Year)   Country)							place (State or Fore ntry)	
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Sherri Killins/D	aughter	1,					ew H	aven,	γ	****		
0a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐	Removal from S	State 20b. F	Place of Dispo cemetery, cre	osition (Nar matory or o	me of other plac	e)		Date	20c. i	Location	- City or To	own, State
4 □ Donation 5 □ Other (Specify	tropol	itan	Crem	atory	7	-2-07	Ale:	xand	ria,	VA		
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State Registrar

33

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, its Medical Examinar must be notified at

Physician /Medical Examiner

within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit To the Hospital or Attanding Physician: The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Takon- Park

20912

MO

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's for tus

7600

7-05039	Please Type or Print in Black Indelible Ink. Ensure All Con	ies Are Legi	ble.	
elesanne Goin	State of Maryland / Department of Health and Mental  1-For State Registrar  Certificate of Death	Hygiene Reg.	. No.	7 22:1
Physiciar Medical Examin		2. Date of Death Month July 2, 2007	Day Year	3. Time of Death 0052 hrs
	4a. Facility Name (if not institution, give street and number)  Holy Cross Hospital  4b. City, Town, or Location of De	ath	4c. County of Death Montgomery	<u> </u>
Funeral Director	000-04-5077 1 M 2XF 43 Yrs.	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bird 1964 Foreig Col	hplace (State or n <b>Trinidad</b> untry)
and f show any.	Usual Residence of Decedent  10a. State			10d. Inside City Limits  1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.		10g	Citizen of What Cour Trinida	-
5-0036 led within 72 hours after death with the Maryland Hygiene. the Medical Examiner must be notified at once.	1 3 Widowed 4 Divorced II Yes Give Year 1 1 Vec 2 X No enacify:		14. Race - Ameri White, etc. Specify: B]	can Indian, Black,  ack
5-0036 ed within 72 hours lygiene. lygiene. when "matury he Medical Exami			6b. Kind of Business/I	ndustry
21215-0036 uld be filed within 72   Mental Hygiene   marked other than "   cevent, the Medical		ame (First, Middle, Ma	•	
2121 Ald be fi Mental narked event,	· [	lis D.Ric		Zin Code O O O A
MD and 2 shoulth and 2 shoulth and 27 is 18 and and and and and and and and and and	Phyllis D.Goin/Mother 13814 Palmer Ho	use Way S	Silver Sp	oring,Md
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N important: If liem 27 is in injury or other traumatin	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State 4 Dogation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crem  7		20c. Location - City or Beltsvil	
Baltin permit. Departm Importa	21. g. re of Funeral S., e Licensee  PHILLIP Address of Facility I.  9241 Columbia	DI FUNERA Blvd.Silv	AL SERVIC	CE,P.A.
Physician /Medical Examiner	23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardla failur. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease or condition resulting in death)	ac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate b bue to (or as a consequence of):			
ited 1 ansit				
be executed sician and urial - transit	X UNPENDED AMENDED NO 7 (07 (07 III)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending physicial property filled in by the furneral director, page 2 should be detached for use as the burities of the state of the property of the state of the property of the state of the property of the state of the property of the state of the property of the state of the property of the state of th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  22c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	gnancy	23d. Date of delivery Month	) Day Year
ries that the deat signed by the at be detached for			acco use contribute to	-
of Vital Records, Ing Physician: The law requires the time of time of the time of the time of time of the time of time		24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
ital Redicion: The scerificate rector, page	25. Was case referred to medical 26.Place of Death (Che examiner?			
on of Vi ending Physi ath. or: After this he funeral dir	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work2	28d. Describe ho	esidence 6 Other w injury occurred	:
Division of Vital Rec To the Hospital or Attending Physician: The lwithin 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str or Town, Sta		ral Route Number, City
To the Hospital within 24 hours To the Funeral completely filled				
To wit To Com	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed <i>(Moi</i>	nth, Day, Year)
	30. Name and address of person who completed cluse of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD		•	
Star Registra	31. Date filed (Nanth, DayYear) 2007 37 Registrar's Signature			
registi	The state of the s			

DHMH 17 Rev 1/2001 OCME 2006

#1- 10thayre

			For State Registrar	State of	Marylan		artment rtificate				lental Hyg	giene Reg. No.	2007	2 %	1, 1,
	Physic		Decedent's Name (First, Middle, L.	.ast) ELIZABET	н соокь	E HOOVI	ER-HII	L			2. Date of Dea Month June	25,	200 <sup>Year</sup>	3. Time o	of Death
	/Medi Examir		4a. Facility Name (If not institution, g	ive street and num	nber)		4b. City, 1	own, or	Location o			4c. C	ounty of Deal	th	
	Funeral Director		5. Social Security Number 215-68-9568	Sex 1 M 2 F	7. Age ( <i>In yr</i> s. <i>I</i> 5	ast birthday) 2 Yrs.	If Under Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da June 17	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) D.C.			
d 21215-0036 illed within 72 hours after death with the Maryland	s 23a or 28a-f show oust be notified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Freder  10e. Street and Number	rick		y, Town or Lo	Ridge					10a Citize	on of What Co	L	City Limits
ath with	s 23a or ust be	ral Di	13820 Motter Sta					778				-	J.S.A.		
036 ours after de	ral', or Items Examinar m	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv. Year or Da	2	1	Vas Decede f Yes, speci l ☐ Yes 2	fy Cuba	spanic Ori n, Mexican Specify:	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, Whit pecify: Wh		
Maryland 21215-0036	ital Hygiene. d other than "natural", event, the Medical Ex	Be Completed by	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usual kind of work DO NOT use	done a	lurina mosi	t of work	ing	16b. Kind	of Business/	Industry	
212 Walt	and Mental Hygiene. Is marked other than aumatic event, the M	Som	Elementary/Secondary (0-12) 12	College (1-	-40r 5+)	New	spape	r C	Lrcu1	atio	n	Ne	wspape	er	
<b>—</b> 0	= 0.3	Be (	17. Father's Name (First, Middle, Las	st)							a (First, Middle,		,		
yaa	Mental Marked o	ပ္	William Hoover							-	h Rando				
, Mar	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any njury or other traumatic e DDCs.		19a. Informant's Name/Relationship Gregory A. Hill		d	1					oad, Ro				78
Baltimore,	nent of He int: If item iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State Ce	lace of Dispo emetery, cren thsbur	natory or oth	ner place	· I		Date / 07		tion - City or	Town, State  Mary1	and
Balt permit.	Departr Imports any nju		21. Signature of Funeral Service Lic	ett.		RC	Name and BERT	Addres E. I	s of Facilit	¥ &	SON, FUN THURMON	ERAL	HOMES,	P.A.	
	nysician Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on ea	used the death ich line.	. Do not ente	ar the mode	of dying	), such as	cardiac	or respiratory ar	rest,	21700	Approxima Interval Be Onset and	tween Death
	xaminer	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a consequence or a consequence or a consequence or a consequence or a consequenc	ence of):	He	PATT	ceiln	lan	Dise	154		Coros	
Ords, P.O. Box 68 requires that the death certifical	igned by the attending ph be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		rth 2 ☐ Fetal int at time of de	death 3	Ectopic pre					230	d. Date of deli Month	,	Year
P.	deta	된	Part II. Other significant conditions	contributing to dea	ath but not resu	Iting in the ur	iderlying car	ise give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of	death?
ords requires	been sign should be	sted by	Emphy sema								1 🗆 Y	es 2 🗆 I	No 3□Pr	obably 4,	tinknown
Division of Vital Records, or Attending Physicien: The law requires t	ste has cage 2	Completed									24a. Was a autop: perfor	sy	prior to death?	topsy findings completion of a	available ause of
of Vita Physiclen:	r this certificete	Be	25. Was case referred to medical examiner?	11							Check only or				
Of O	<u>∞</u> <del>⊙</del>	၉	1 ☐ Yes 2 ☑ No		patient 2 2			Othe	r: 4□Nui		me 5. Resid			cify)	
Sion (	eath. or: After the funer	Certification:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not		njury , Day Year)	28b. Time of Injury	M 28	c. Injury Work 1 🗆 Y	at ? 'es 2 ☐ ñ		28d. Describe h	ow injury o	injury occurred		
Divi	rs efter d al Direct ed in by	Certifi	3 Suicide 6 Could not 4 Homicide determine	4   288. Place (	of Injury - At hor g, etc. (Specify)	me, farm, stre	et, factory,	office			28f. Location (S City or Tow	treet and N n, State)	Number or Ru	ral Route Nun	1ber,
iqsoH er	within 24 hours efter death.  To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)	hysician: To the laminer: On the bar and manner	sis of examinati	vledge, death ion and/or inv	occurred at estigation, i	the time	e, date and inion, deat	d place, h occurr	and due to the c ed at the time, c	ause(s) and date and pl	nd manner as ace, and due	stated. to the cause(s	s)
To th	withii To th	ž	29b. Signature and title of certifier	/					number	_	2	.2	igned (Monti		
			1/750	<u></u>			Do	200	515	Z		6	26.0	7	
a			30. Name and a dress of person who		of death (Item	23a) (Type, I	Print)	57.	7	Lura	novi A	10	2178	88	

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 8 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

- 6.	-Bet	1 - State Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of De Month		Vaar	3. Time of Dea
hysici /Medic		Mary Elizabeth	Н.	ayghe		June	30	Year 2007	
Examin		4a. Facility Name (If not institution, give street and number)		1	r Location of Death		4c. Co	ounty of Dea	ath
and a second		5236 Beaver Neck Village		Link				rchest	
uneral rector		1 M 2 XF	'In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	y, Year)	C	rthplace (State or For ountry) <b>cyland</b>
ow at			0c. City, Town or L	ocation					10d. Inside City Lir
fled a	tor	Maryland Dorchester	Linkw	ood					1 □ Yes 2 🛣
r 28e	irec	10e. Street and Number	Dille	10f. Zip Code			10g. Citizei	n of What Co	ountry?
23a c	al	5236 BEaver Neck Village Ro	ad	2183	35		U	SA	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status  12. Was Decedent Eve Armed Forces?  1 □ Never Married 2 Married 1 □ Yes 2 No	er in U.S. 13.	. Was Decedent of H If Yes, specify Cuba		pecify Yes or No o Rican, etc.)	14.	. Race - Ame Black, Whi	erican Indian, ite, etc.
ural", o al Exam	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	140.0	1 ☐ Yes 21 No					Vhite
"nat edica	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind	of Business	/Industry
than he M	Ę.	Elementary/Secondary (0-12) College (1-4or 5+)		se Cleanir			So.14	f Empl	lowed
other ent, t		17. Father's Name (First, Middle, Last)		se Cleanin	18. Mother's Nam	ne (First, Middle,			loyeu
ked c	To Be	George Thomas Joh	nson		Dorothy	A	nn	Faur	nce
mar	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street	and Number or Ru	ral Route Numb	er, City or T	own. State.	Zip Code)
27 is r tra		Kathy L. Mendoza/Daughter	l l	30 Jones (					
item		20a. Method of Disposition	20b. Place of Disp		- ;	Date			r Town, State
tant: If ijury or		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Breinsf	ield-Echol	Ls 7/6/	2007	Charle	otte H	lall, MD
any Ir		21. Signature of Funeral Service Licensee	2	22. Name and Addres	ss of Facility	Funeral	Home	, P.A.	
sician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one causage each line. Immediate Cause (Final disease or condition	e death. Do not er	30195 Three the mode of dying	ee Notch g, such as cardiac	Rd., Ch	arlot	te Hal	Approximate Interval Between
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **GAYLORD** DANIEL HALL 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 7. Age If Under 1 If Under 24 Hrs 8. Date of Birth (Month, Day, In yrs. last birthday) 9. Birthplace (State or Foreign 138-14-5517 Days 86 Months Hours 1**X** M 2□ F 10, 1920 NEW YORK AUG. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County TALBOT **EASTON** 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? FORTH STREET 21601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 130 Yes 2 □ NMERCHANT 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: WHITE **MARINES** 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AREO SPACE College (1-4or 5+) MECHANICAL DRAFTSMAN MANUFACTURING

Department of Heal Important: If Item 2 any Injury or other lfimore, Pages 1 **Physician** /Medical

**Physician** 

/Medical

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Division or Vital Records,

The law requires that the death certificate be executed certificate or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital

State Registrar

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perilliniore, Inial yial in A 12.13-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked or other than "natural; or items 23a or 28e-1 show any injury or other traumatic event. Ite Medical Exertment or published any injury or other traumatic event.		Dy Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes If Yes, Gi	<sup>2</sup> ₩No		□Yes 2□Xio	Specify:		Specify:	Whi	te
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5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Walter K. Naumann, 106 Cemetery Rd., Accident, MD  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ing P	0	1 25 Natural 5 ☐ Pending	(Month, Day	Year) 28b.	Injury				8d. Describe h	ow injury occu	rred		
5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Walter K. Naumann, 106 Cemetery Rd., Accident, MD  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	tend death tor: /	cat	Z Nooldon		. At home for	····		Yes 2 N		of Location /C	troot and Num	har or Pura	al Pouto Mumbas	
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5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Walter K. Naumann, 106 Cemetery Rd., Accident, MD  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	spitai ours e ierai I	O	29a Certifier 15 Certifying Pt	vsician: To the best of	my knowleda	e, death occurre	ed at the tin	ne date and	d place at	nd due to the o	ause(s) and m	anner as e	tated	
5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Walter K. Naumann, 106 Cemetery Rd., Accident, MD  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Hos 24 h Fur etely	d	(Check only 2 Medical Exal	niner: On the basis of e	xamination ar									
5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Walter K. Naumann, 106 Cemetery Rd., Accident, MD  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	To th within To the	Me	29b. Signature and title of certifier		11	2	29c. License	e number		2	9d. Date sign	ed (Month,	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Walter K. Naumann, 106 Cemetery Rd., Accident, MD  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature			MINIT	Man	-111	/	D0025	5759			Trans	30.	2007	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		500	30. Name and address of person who	completed cause of dea	ith (Item 23a)	(Type, Print)					July Co	1		
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Registrar JUL - Z. ZUU/ Andrews July - Z. ZUU				32. Registrar	s Signature	Somala	50							

Baltimore, maryland 21215-1	Phy /N Exa	/sic led ami	and the medical state of the m
DIVISION OF VITAL RECORDS, P.O. DOX 56750,	Hospitel or Attending Physician: The law requires that the death certificate be executed the property of the control of the co	Funerel Director: After this certificate has been signed by the ettending physicien and	tely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - For State Registrar	State of Marylar		artment rtificate			d Menta	l Hygier	L. U. I	22455
Physic	ian	1. Decedent's Name (First, Middle, Las	t)					Moi		ay Year	
/Medi		Marietta Whittingt							5/25/20		04:00an
Exami	ner	4a. Facility Name (If not institution, give Genesis Elder Care					Location of D Park	eath		lc. County of Dea Anne Aru	
		5. Social Security Number 6. Sec		. last birthday			If Under 24	Hrs. 8. Date	e of Birth nth, Day, Yea		rthplace (State or Foreign ountry)
Funeral Director				90 Yrs.	Months	Days	Hours N	1in. (Mo 9/:	nth, Day, Yea 19/1916	Mar	yland
		Usual Residence of Decedent	10-0	the Town and							10d. Inside City Limits
arylar ehow	-	10a. State 10b. County		ity, Town or L							1 Tes 2 No
the M	Director	MD Anne Arur	idel S	everna	10f. Zip	Code			10g. (	Citizen of What C	
with the same	급	24 Truckhouse F	load			2114	6			USA	•
death me 2;	Funeral	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Deced	ent of Hi	ispanic Origin' n, Mexican, P	(Specify Ye	s or No-	14. Race - Arr Black, Wh	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow entry injury or other traumatic event, the Moultest Examination and once.	þ	1 ☐ Never Married 2 ☐ Married  XXWidowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 🏂		Specify:	John Mican,	310.)	hite	
in 72 ho	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						Kind of Busines	s/Industry
d with giene er tha	E O	12 Receptionist								USNA	
al Hy	Be	17. Father's Name (First, Middle, Last)					18. Mother's				
Ment Ment arked	2	Russell Whittingto							Peddic		
2 should and is m		19a. Informant's Name/Relationship (1911) Holly Besau Daug	Type, Print) Shter	1	-	•	a <i>nd Number</i> o e <b>Riv</b> a			or Town, State,	Zip Code)
1 and 1 and 1 ealth 1 mm 27		20a. Method of Disposition	<u></u>	Place of Disp	osition (Nam	ne of		Date		Location - City o	r Town, State
ages nt of h		1 ☐ Burial 2 【Cremation 3 ☐	Removal from State	cemetery, cre	matory or of	her place		26/2007		Ltimore,	
artme bortent injury		4 □Donation 5 □ Other (Specify 21. Signature → Funda al Service Licen	A							eral Hom	
Deparim Impo		) Bat 1 (1)	1/6							ش 21401	
Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. SEPS1-	\$	iter the mode	of dying	g, such as car	diac or respir	atory arrest,		Approximate Interval Between Onset and Death
Examiner	١.	Sequentially list conditions,	Due to (or as a conse								
ed Isit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence or):							
be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):							
te be e ysicler	calE	l	d								
ifficate g phys											
to the Hospitel or Attanding Physician: The law requires that the death certificat if the Vous attendeath.  The law requires that the death certificate has been signed by the ettending phy on the Funerel Director: After this certificate has been signed by the ettending phy ompletely filled in by the tuneral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pre □ Other (spe					23d. Date of d Month	elivery Day Year
s that ned b	by P	Part II. Other significant conditions c						23	e. Did tobacc	o use contribute	to the cause of death?
w requires been sign should be		ARTERIOSCI	ENUTIC CA	40101	ma	M	e DEE	M	1 🗌 Yes	2 □ No 3 □ F	Probably 4 Hinknown
The law re rate has bee page 2 sho	Completed	DEMENTIA						-   -	a. Was an autopsy performed	prior to	
ician: Th certificate ector, pag	a)	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·			26. Place of	Death (Chec	Yes 2024 k only one)	1 □ Y€	s 2 No
ysician: nis certific director,	To B	examiner? 1 Tes 2 PNo	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatie	nt 3□ DO	A Othe	ar /			6 □Other (Sp	ecify)
ding Ph h. After th funeral		27. Manne of Death  1. Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28	Bc. Injury Work	/at k? Yes 2 □ No	28d. De	scribe how in	jury occurred	
lel or Attandi s after death.	Certification:	2 Accident investigation 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)									Rural Route Number,
To the Hospitel or A within 24 hours after To the Funerel Direct Completely filled in by	edical (	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exert	ysicien: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, dea nation and/or in	th occurred anvestigation,	at the tim	ne, date and p pinion, death o	lace, and due	to the cause e time, date a	(s) and manner and place, and de	as stated. ue to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier		Λ.,	29c	. License	e number	. 1	29d. I	Date signed (Mon	nth, Day, Year)
600	C		·	M)	Price*	リ	2177	6	10	NE 21	nth, Day, Year) 0, 2007 My 21/22
, Co		1	MORAMO	80U	P170	Chit	= HU	17 8.	MADE	sua 1	M) 21/22
St	ate	31. Date filed (Month, Day, Year) JUN 2. 6. 28	32. Jegistrar's Sign	Iature	land.						

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		1 State	State of Marylan	d / Department of Health and	Mental Hygie	ne
		Registrar		Certificate of Death	Reg.	No. 1
Physi	rian	1. Decedent's Name (First, Middle, Las	" 11 10		2. Date of Death  Month	3. Time of Death
/Med		Nary O.	Haskins		June à	5, 2007 9:41PM
Exam	iner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Death
		ST. Thomas	More Illursi	natad Huattsville		Prince Georges
Funera	i	5. Social Security Number 6. So		Months Days Hours Mir	S. 8. Date of Birth	ar) 9 Birthplace (State or Foreign Country)
Directo	r	224-30-2976	DM 2 <b>X</b> F 83	Yrs. World Bays Hours	S. 8. Date of Birth Month Day, Ye	3 Virginia
pu ,		Usual Residence of Decedent				3
aryla shov	_	10a. State 10b. County	10c, Cit	y, Town or Location		10d. Inside City Limits
e Ma ba-fs	양	DiCi	u	ashington		Yes 2 No
th th or 28	Sire	10e/ Street and Number	111	TL 10f. Zip Code	10g.	Citizen of What Country?
th will stand	ie i	1/2/25 446 5	treet, N.U	1508 20011		10.5.
ING 21215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
afte or it		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No If Yes, Give	d'	nto nican, etc.)	Atrican-America
Ours ral", Exa	by	3 Widowed 4 □ Divorced	Year or Dates:	1 ☐ Yes 25 No Specify:		Specify:
5-0036 72 hours af natural", or dical Exami	Completed	15. Decedent's Ed (Specify only highest grad	acation	16a. Decedent's Usual Occupation (Give kind of work done during most of w	16b	. Kind of Business/Industry
Me a . E	횰	Elementary/Secondary (0-12)	College (1-4or 5+)	life. PG NOT use retired)	Orking	0 6 1
d 21 filed wi Hygien rither th	Š	12		Homemaker		Private
Seffice of the seffic	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Maid	den Surname)
	10	Frank tood		May	rine 1	lells
and Nama		19a. Informant's Name/Relationship (7	/pe. Print)	19b. Mailing Address (Street and Number of F	Rural Route Number, Cit	ty or Town. State. Zip Code) -2 A TITO
		I trankie Has	Kins-Son	3611 Evre Dr. 1	SO, Hoper	Marl har mo
Ire, Marylis s 1 and 2 should if Health and Mei item 27 is marke other traumatic		20a. Method of Disposition		lace of Disposition (Name of	Date 20c	Location - City or Town, State
0 0	1 8	1 Buria! 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State	emetery, crematory or other place)	20 001	- 1 m. 1.
<b>Saltimore</b> , bermit. Pages 1 al mportant: If item: mportant: If item: any injury or otherance.		21. Signature of Funeral Service Licens		22. Name and Address of Facility	30-011K	intell llargiana
Baltimo permit. Page Department. Important: If any injury of		1-0 50	7	2 2501 2016 CT	onnette +H	550C. Furteral Home
		220 Part Enter the disease or come	Min	2304 28 411 St,	N.E., W.D.E	20018
				. Do not enter the mode of dying, such as cardia		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Arterio	scherote Caudio	Vascular	DISCLAR CHEAKS
/Medical Examiner		resulting in death)	Due to (or as a consequ			100
Lammer		Sequentially list conditions.	b			
p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dus to (or as a consequ	isnos of).		
ecute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	o			
e exitan a		resulting in death) Last	Due to (or as a consequ	ence of):		
rificate be executed g physician and as the burial-transit	ledical		d			
entific ing p	Med	IF FEMALE:				
th ce	Jue I	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal	ncy death 3 Ectopic pregnancy		23d. Date of delivery
dea the att	Sici	in the past 12 months? 1 □ Yes 2 No	4☐Pregnant at time of de			Month Day Year
by the tach	Physician/IV	9 □ Unknown ³	9□Unknown			
s tha	by F	1		Iting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
v requires to been signer should be considered.	b	Demontes	Braheres	hiellitus	1 ☐ Yes	2 No 3 Probably 4 Inknown
vical necords, F.O. box sician: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use	Completed	Candionyou	A the A	remia	24a. Was an	24h Were autoney findings available
he la e has	Ĕ	~	Vicers		autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
cian: T		25. Was case referred to medical	Viars		1  Yes 2	Vo 1 ☐ Yes 2 ☐ No
sicia cert	o Be	examiner?	Hospital:		ath (Check only one)	
ding Physician: The h. After this certificate h. After this certificate h. funeral director, page	$\vdash$	27. Manner of Death	1 ☐ Inpatient 2 ☐ E	4 Invursing I	Home 5 Residence	
ding F h. After funera	Certification:	1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	Injury Work?	28d. Describe how in	jury occurred
ttend death death stor:	cat	2 Accident investigation 3 Suicide 6 Could not be	20a Blace of initial At his	M 1 Yes 2 No	111	
or Attendate death Director: in by the	ŧ	4 ☐ Homicide determined	building, etc. (Specify	ne, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
pital ours a eral filled		One Continue of Continue Division Divis	1-1 - <del>T</del> - 1 - 1 - 1 - 1		N .	
To the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director: After this certification of the funeral director, the funeral director director, the funeral director director, the funeral director director director, the funeral director dir	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis of examinat	rledge, death occurred at the time, date and plac on and/or investigation, in my opinion, death occ	e, and due to the cause surred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
thin 2	Med		and manner stated.			
F 3 8		29b. Signature and title of certifier	· /2 .	29c. License number		Date signed (Month, Day, Year)
(4)		Vanel	neure	m 0185	2 3	UNE 76 5001
Occo		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	0.0	
ge		11 AVI 4. 150	-VOICE MI	4203 Queensbu	ry Kd Hy	4 1750; 1(4M) 478
	ate	31. Date filed (Month, Day, Year) JUN 2 8 2007	32. Registrar's Signat			
Regist	rar	JOH W O LOOP	an 1. 17			

Registrar DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of I	Marylan		artment of				giene Reg. No.			
			1. Decedent's Name (First, Middle, La	st)			<del></del> -			2. Date of De	ath		3. Time of Death	
	Physici /Medio		Wilmont Hightowe	ers						Month June	Day 25		4:25 P <sup>M</sup>	
	Examir		4a. Facility Name (If not institution, giv	e street and numbe	er)		4b. City, Town	n, or Locati	on of Death		4c.	County of Deal		
			Heartland Health	Care Cen	ter		Adelr	hi			Pr	ince Ge	orge's	
	Funeral		Social Security Number 6. 5		Age (In yrs.	last birthday)	If Under 1 Ye			8. Date of Bir	th	9. Birt	hplace (State or Foreign	
	Director		184-10-4177	IXM 2□F	91	Yrs.	Months Da	ys Hou	rs Min.	(Month, Da Jan • 1			nuntry)	
	Б _		Usual Residence of Decedent											
	ahow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	
	Ba-f-	cto	DC		Was	hingto	n						1½TYes 2□No	
	or 24	Director	10e. Street and Number				10f. Zip Cod	е			10g. Citiz	en of What Co	ountry?	
	72 hours after death with the Maryland natural', or items 23a or 28a-f ahow Jical Ezaciliker must be trofffied at	a	132 Michigan Ave	nue NE,	P24		20017	<u> </u>			USA			
	e ma	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U. s?	.S. 13.	Nas Decedent of Yes, specify C	of Hispanic Juban, Mex	Origin? (Speican, Puerto	cify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, White		
36	or it		1 Never Married 2 Married	15 Yes 2			1 □ Yes 2√2 /	No Spec	cify:			Specify: B1		
8	ural	d by	3 Widowed 4 Divorced	Year or Date	s:									
Γγ		Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	lent's Usual Oc kind of work do	ne during n	nost of worki	ng		nd of Business/	•	
12	e filed within 72 hours after death with the Marylan al Hygiene other than "netural", or flems 23a or 28a-f ahow vent, the Medical Eraculaer mast ke notified at	m d	Elementary/Secondary (0-12)	College (1-4d	or 5+)		OO NOT use re	irea)		i		er Reed	•	
22	filed Hygie ther ant, II		12th 17. Father's Name (First, Middle, Last	1		Chier	Cook	19 14	other's Name		Medical  Middle, Maiden Sumame		ter	
anc	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 2008.	Be	Willie Hightowe					10. 1410						
Ë		WIIIIe Hightowers Elizat  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Rot									abeth Baldwin			
Maryland 21215-0036	d 2 si th an 7 is r traur			,										
	1 and Healt em 2 ther		Sarah T. Hightowers/wife 132 Michigan Ave NE, P24, Washin 20a. Method of Disposition (Name of Date 20c.										20017 Town, State	
altimore,	ages if it		1 ☑ Burial 2 ☐ Cremation 3 ☐			emetery, crer	natory or other	olace)	1			•		
ij	artme ortant injury	' 4 □ Donation 5 □ Other (Specify) Indiantown Gap   7-03-2007								Ann	ville,			
Ba	Depariment of the parameter of the param	Marchall's Funoral Home (217.0+b)											20011	
	20240	Marshall's Funeral Home 4217 9th S  23a. Part I Shter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.										n St Was	Approximate	
	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, land the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a consequence of scler as a consequence of sclerost as a consequence of	osis H	tion eart Di	sease	1				Onset and Death	
.O. Box 68760,	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Ex	d									3d. Date of deli Month	very Day Year	
<u>α</u>	that ti		Part II. Other significant conditions of	ontributing to death	but not resi	ulting in the ur	nderlying cause	civen in Pa	urt I.	23e. Did to	obacco us	se contribute to	the cause of death?	
ds,	sign d be	d by	Multi organ fail				, ,			101	res 2□	No 3⊟Pro	obably 4 Munknown	
Ö	v requir	ete		ur c						-				
Vital Records,	has has	ompleted								24a. Was autop	an isy rmed?	prior to death?	topsy findings available completion of cause of	
<u></u>		O								1 ☐ Yes	2X No		2 No	
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:					ace of Death	(Check only o	ne)			
of	shys this al dii	To	1 ☐ Yes 2 🛣 No	1 🗆 Inpa		ER/Outpatien	3 DOA					Other (Spec	cify)	
<u></u>	ding Ph h. After th funeral	lon	27. Manner of Death 1 Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	V	liury at Vork?		8d. Describe h	now injury	occurred		
Division	tend jeath tor: the t	Certification;	2 Accident investigation 3 Suicide 6 Could not b					☐ Yes 2	_					
<u>≥</u>	or Al fler c Direc in by	it.	4 Homicide determined	28e. Place of I	etc. <i>(Specif</i> )	me, tarm, stri /)	et, factory, office	Э	2	City or Tou		Number or Ru	ral Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	Check only 2 Medical Exar	ysician: To the be	of examinat	wledge, death	occurred at the	time, date	and place, a	nd due to the ded at the time, d	cause(s) a	and manner as	stated. to the cause(s)	
	To the within 2. To the complet	Med	Direy 2	and manner	stated.									
1	To Too	-	29b. Signature and little of certifier				-	ense numbe				signed (Month		
ľ	6		Muli					609			6.9	27.0.	7	
	Bi		30. Name and oddress of person who					ior	MD 207	112				
-			Raman Tuli, MD	3503 Peri			r. Kallı	Ter,	rш 207	17				
	Sta	te	31. Date filed (Month 2007 ear)	32. Re	strar's Strar									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 4:00 Meta В. a Husted Tune 26, /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11530 Lockwood Dr., #D2 Silver Spring If Under 1 Year | If Under 24 Hrs. | Montgomery | 9. Birthplace (State or Foreign | Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2**7** F Yrs. **Director** 280-30-6069 90 Sept 14, 1916 Germany Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11530 Lockwood Dr., Funeral 20904 #D2 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: White ģ 3√Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker other Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Hy Important: If them 27 Is marked oth any injury or other traumatic event once. Be 2 Hans Schur Katharina Prom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11530 Lockwood Dr., #D2, Silver Spring, MD 20904 ace of Disposition (Name of Date 20c. Location - City or Town, State Stephen M. Husted /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Arlington National Cemetery Jul 18, 2007 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. p00 University Blvd., W, Silver Spring, MD 20901 23a. ea/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Acute Renal Failure Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Dementia and Due to (or as a consequence of): Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Dehydration

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After t 124 hours a To the I within 2

rilled in by the f

Be 2

Certification:

Medical

State Registrar

10

		performed? death? 1  Yes										
25. Was case referred to medical examiner?	26. Place of D	26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing											
27. Manner of Death 1		28d. Describe how injury occurred										
3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of my knowledge, death occurred at the time, date and pla miner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.	ace, and due to the cause(s) and manner as stated. courred at the time, date and place, and due to the cause(s)										
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)										
	Ch (//merill) pooceoco	7 06 0007										

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sirak Lemma 1500 Forest Glen Rd., Silver Spring, MD

31. Date filed (Month, Day, Year)

JUN 2 7 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Vear JOE JOHNSON JULY 2007 9:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST. MARY'S 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☑ M 2 🗆 F 215-20-3806 SEPT. 24,1928 INDIANA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD CHARLES HUGHESVILLE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5295 WOLFE DRIVE 20637 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 146-149 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) SHOP MECHANIC POWER COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWIN NATHAN JOHNSON RUBY ANN KELLY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. JOHNSON / WIFE 5295 WOLFE DRIVE HUGHESVILLE, MARYLAND 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State h Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY JULY 11,2007 CHELTENHAM, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL.HME., P.A. M00641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gerebrovascular 10 days Due to (or as a consequence of) Arteny ischemia Middle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown ibbrill ation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an Dementi 1□ Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 No (Specify) 27. Manner of Death

**Physician** /Medical Examiner Examiner be executed

Physician

/Medical

Director

Funeral

þ

Completed

Be

**Examiner** 

**Funeral** 

**Director** 

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Records,

or Vital

Division or Attending

To the

2 should be filed win and Mental Hygier

permit. Pages 1 and 2 :
Department of Health ar
Important: If Item 27 Is
any Injury or other trau

burial-trar physician the as attending properties for use as signed by the a page 2

Physician/Medical þ Completed certificate has director, Be Certification: To this After 1 death. Director: the in by within 24 hours a To the Funeral I

5 Pending investigation

1 Natural

29a, Certifier

2 Accident

			20	. I lace of Dec	tui (O	reck only one)	
ospital: 1 🗌 Inpatient 2	☐ ER/Outpatient	3 🗆 🗆	OCA Other:	Uursing H	lome	5 ☐ Residence	6 ☐Other
28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work?	2 🗆 No		Describe how in	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	and mainer stated.	
29b. Signature and title of certifier	01	29c. License number
VP2. 1	Alperia	DUSAGO

29d. Date signed (Month, Day, Year)

30. Name and address of person who com pleted cause of death (Item 23a) (Type, Print) 110 Hospita

Registrar

Medical

31. Date filed (Month, Day, Year) ZUU7

ŧ	e con	tribute to the cau	use of death?
	No	3 ☐ Probably	4 Unknown
	24b.	Were autopsy fin prior to completi death?	

Day

Year

3. Time of Death

2:10 P

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Minutes

1 XYes 2 □ No

Mary land

Black

USA 14. Race - American Indian.

Black, White, etc.

Specify.

25. Was case referred to medical examiner?

1 Inpatient

28a. Date of Injury (Month, Day Year)

	heck only one)	
ome	5 Residence	6 □Other (Specify)
28d.	Describe how Inj	ury occurred

2 No 27. Manner of Death 1 ⊠ Matural 2 ☐ Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 Suicide 4 ☐ Homicide

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

29a. Certifier (Check only one)

1 Tes

1X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

26. Place of Dea Other: 4 Nursing H

Hospital:

D47221

28c. Injury at Work?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

29d. Date signed (Month, Day, Year) 6/19/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip R. McDowell M.D. 6701 N. Charles St. Baltimore, MD 21204

State Registrar

director,

filled in by

completely

Be

Certification: To

Medical

31. Date filed (Month, Day, Year) JUN 2 2007

Division or Vital Records, P.O. Box 68760, Physician: this After death. 24 hours after death Funeral Director:

Hospital or Attending within 2

2

DHMH 17 Rev 1/2001

Registrar

JUN 1 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** JOHNSON - EACUAN /Medical 15 2007 4a. Facility Name (If not institution, give street and fumber) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALTIMORE UMMC TRAUMA DIHOUL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 2□F Days Hours 216 33 5785 Director July 27, 1991 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Examiner must be notified at 1 Ves 2 No Director Talbot ordoya the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Items 23a or 29927 Skipton-Cordova 21625 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No δ Black 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) High School Student trent of Health and Mental Hygant: If item 27 is marked in try or other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SRI Johnson, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Pordova Ruad -Cordova, MD. 21625 Leslia 299275K: ptc
20b. Place of Disposition (Name of cemetery, crematory or other place) Johnson 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/07 Richards Mem. Park 6/23/07 22. Name and odress of Facility ITENRY Funckal Home, RA. Easton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Henry 510 washington St. Cambridge, MD. 21613 23a. Part Lenter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Acuns BLOOD LOSS /Medical resulting in death) Due to (or as a consequence of): Examiner ANCREATIC NOUP Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner FORTON APPROVED BY MEDICAL certificate be executed physician and s the burial-trans 165ENTERIC INTUF Due to (or as a consequence of): Box 68760, Physician/Medical EMORRHAGIC SHOCK the as attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has by page 2 s autopsy certificate Vital 1☐ Yes 2 Z No : After this certifical funeral director, p Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 12 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Division or 28d. Describe how injury occurred Subject driver Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation To the Hospital or Attending Injury 1 Natural 15 2007 1 ☐ Yes that struc 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the death. 1:11 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 5 Kipton Cordova 4 Homicide STREET and Blodes Roads, Comova, MA ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of reyamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cen 29c. License number 29d. Date signed (Month, Day, Year) AUX176435616759 ID# 1675 LAWNEY who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21201 UMMS 22 SOUNI GREENE ST trar's Signature 31. Date filed (Month. State

Registrar

State of Maryland / Department of Health and Mental Hygiene , Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:00 AM **EVELYN** 2007 **JAMES** JUNE 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CRESCENT CITIES CENTER PRINCE GEORGE'S RIVERDALE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 □ Director VIRGÍNIA 579-26-9609 95 APRIL 4 1912 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director PRINCE GEORGE'S CAPITOL HEIGHTS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 27 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be i 1207 ADDISON ROAD SOUTH # 243 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 💢 No Specify: 2 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERTHA CHINN WILLIAM MARSHALL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 2702 MILLWOOD WAY MITCHELLVILLE, MARYLAND Health tem 27 I EDWIN JAMES/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 6/26/2007 LAUREL, MARYLAND MARYLAND NATIONAL onation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility Sign 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) PANCREATIC CANCER /Medical Due to (or as a consequence of) Examiner STRUKE

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed and burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2x No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🖾 No 1 Yes 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 $\boxtimes$  Nursing Home 5 $\square$  Residence 6 $\square$ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending nours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral t

completely filled Hospital 1 [X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25079 June 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B

DHMH 17 Rev 1/2001

State Registra

DON YABLONOWITZ M.D.

SEABROOK LANHAM, MARYLAND 20706

7404 EXCCUTIVE PLACE # 505

32. Resistrar's dinatural

			For State	State	of Mar	yland		artment of H			lental Hyg	giene		
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	Physici		Decedent's Name (First, Midd     Samue 1	<sub>le, Last)</sub> Jackson							2. Date of Dea Month June	Day 22	Year 2007	3. Time of Death 2:33PM
	/Medio		4a. Facility Name (If not institution		ımber)			4b. City, Town, or	r Location	of Death	oune	4c. County of Death		
			Washington	Adventis	t Ho	spita	1		Takoma Park				omery	
	Funeral		5. Social Security Number	6. Sex 12 M 2 F	7. Age (	'In yrs. las	t birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
ш	Director		224-44-2923	1( <u>4</u> MM 2   F		72	Yrs.	Months Days	Tiodis			, 193	35 Coui	"'Yirginia
	and w		Usual Residence of Decedent  10a, State 10b, County	,		0c. City, T	own or Lo	cation					Ι.	10d. Inside City Limits
	Maryll f sho	ō	DC			,,,,,			1. 3					1 X Yes 2 □ No
	the 1 28a- notifi	Director	10e. Street and Number					10f. Zip Code	hingt	LOII	1	IOa Citizen	of What Cou	
	3a or		2954 N	ash Place	. SE	#10	1		2001	9			ed Sta	•
	death ms 2	Funeral	11. Marital Status	12 Was Der	edent Ev			Was Decedent of Hi If Yes, specify Cuba			ecify Yes or No-		Race - Americ	
98	tiges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 🛣 Mar	If Yes, G	2 <b>∑ÃN</b> o ive			nr Yes, speciny Cuba 1 □ Yes 2 🛣 No	an, Mexica Specify:		Hican, etc.)		ecify.	ican
Maryland 21215-0036	hour tural	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:		I6a Decer	dent's Usual Occup	ation				Ame:	rican
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pu	be filed tal Hygid d other event, the	Be	17. Father's Name (First, Middle	Last)			- 1		18. Mothe	er's Name	(First, Middle, I	Maiden Sur	rname)	
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d'	1 and 2 Health em 27 i		Bernice Jack 20a. Method of Disposition	son/Wife		20h Plac		+ Nash P1 sition (Name of	., SE					
Jor	ages nt of :: If its		1 Burial 2 ☐ Cremation		State	cem	etery, crer	matory or other place		6/28			on - City or To	
altimore,	oit. Partme	l	4 □ Donation 5 □ Other (S		1	Geda		. Name and Addres			Stewart		and, M	
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot	0 0	- 1 Star 1	5/000	#	111		4001 Be:		,				
			23a. Part1. Inter the disease, o shock of heart failure. Lis	complications that	caused h	e death. I	Do not ent	er the mode of dyin	g, such as	cardiac c	or respiratory arr	est		Approximate Interval Between
	Physician	a H	Immediate value (Final disease or car dition		or	13	mv	ascu	110		n.cci	din	+	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a c	onsequen		0-7-0-0	100	(	209	0000	/	
	LXaiiiiiiei	<u>.</u>	Sequentially list conditions,	b. —	for an a c	onsequen	AA 778						_	
	nsit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Suc to	(01 43 4 6	onsequen	oe oi).							
Ć.	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	C	(or as a c	onsequen	ce of):							
8760,	te be ysicia ne bur	dical		d										
9	rtifica ng ph as th	Ned	IF FEMALE:											
Вох	ath ce ttendii	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou 1 ☐ Live		pregnancy ⊒Fetal de		Ectopic pregnancy				23d.	Date of delive	,
0	ires that the death certific signed by the attending is the detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unkr		ne of deatl		Other (specify)	_				Month	Day Year
Δ.	that the set by detac	Ph	Part II. Other significant conditi	ons contributing to d	eath but r	not resultin	a in the ur	nderlying cause give	en in Part I		23e. Did tol	nacco use o	contribute to the	ne cause of death?
Vital Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	d by									1 □ Ye			
000	s been s	olete									24a. Was a	n 24	4b. Were auto	psy findings available
Ä	The lay	Completed									autops perforr 1□ Yes	sy	prior to co death? 1 ☐ Yes	mpletion of cause of
ita	ilcian: Th certificate ector, pag	Be C	25. Was case referred to medica examiner?	i					26. Place	of Death	(Check only on			26.140
-	Physic this or al dire	2	1 Yes 2 No		Inpatient	2 🗆 ER/	Outpatien	t 3□ DOA Othe	er: 4 🗆 Nu	ırsing Hor	ne 5 🗆 Reside	ence 6 🗆	Other (Specif	<i>y</i> )
Division or		ii o	27. Manner of Death 1 ☑ Natural 5 ☑ Pendir		of Injury hth, Day Y	ear) 28	b. Time of Injury	Work			28d. Describe ho	ow injury oc	curred	
Sic	Attender death	icat	2 Accident investigues 13 Suicide 6 Could	not be	of Injuny	- At home	form etro	M 1 1	Yes 2 □		Of Landing (Of			/D 11
<u>≥</u>	affor affer	Certification:	4 ☐ Homicide determ	build	ing, etc. (	Specify)	, raim, suc	set, factory, office		1	City or Towr	n, State)	umber or Hura	l Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifylm	ng Physician: To the	e best of r	ny knowle	dge, death	occurred at the tim	ne, date an	nd place, a	and due to the ca	ause(s) and	d manner as s	tated.
1	the Hin 24 the Figure 14 the F	Medical	CITE)	Examiner: On the band man	ner state	tamination f.	and/or inv			ath occurre	ed at the time, d	ate and pla	ce, and due to	the cause(s)
	with con	2	29b. Signature and title of certife	1/LU	re	17.	e	29c. License	number	W.	7-1 2	9d. Date sig	gled (Month,	Day, Year)
	4	-	20. Name and address of the			h //4 0-	a) (T	J. L.	7 -	-1	/ /	61	23	1200+
	1		30. Name and address of person	wito completed caus	e of deat	(Item 23	a) (Type, i	IN CE	This	161	010	adi.	unh	OF HOSA
<b>15</b>	Sta	te	31. Date filed (Month, Day, Year)		Registrar's	Signature	Ass.	V 40	17(	19	V V/ 1	UV	0111	1 IV-F
	Registra	ar	JUN 2 8 20	Bered	1	9. 19	jule			_				

			1 - For State Registrar		iaryian		rtificate of	Death	nental H	ygiene Reg. No.	00		
-1	Physic	ian	1. Decedent's Name (First, Middle, La						2. Date of D Month	eath Day	Year	3. Time of Death	
-Q:	/Medi		Herbert Junior						June	27	2007	5:00 A <sup>M</sup>	
	Examii	ner	4a. Facility Name (If not institution, give	e street and number	)			or Location of Death			4c. County of Death		
	F	_	Hilltop Manor  5. Social Security Number 6.5	Sex 7. A	ne (In vrs. I	ast birthday)	Risir If Under 1 Year	ng Sun	8. Date of B		Ceci1		
II.	Funeral Director			1 X M 2 □ F	80	Vro	Months Days	Hours Min.	(Month, D	lay, Year) 18, 1926	Cour		
2			Usual Residence of Decedent			,			NOV .	10, 1920	Peni	nsylvania	
	ırylan ihow Lat	_	10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits	
:	e Ma 3a-f s tifiec	Director	Maryland Harf	ord	S	treet						1 □Yes 2 No	
3	or 28	Fig	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?	
:	ath w	-E	3207 Sandy Hook				21	154		USA			
	o within 72 hours after death with the Maryland sjene. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13. V	Was Decedent of H f Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or N Rican, etc.)	o- 14. Ra Bla	ce - Americ		
9	rs aff	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give			I□Yes 2XINo	Specify:		Spec	fv:		
9500-612	nou Itural	ed t	15. Decedent's E	Year or Dates:	WWII	16a Decer	lent's Usual Occup	antion			W	hite	
2	nn /2 n "na Aedio	plet	(Specify only highest gra	ade completed)		(Give life, L	kind of work done  OO NOT use retire	during most of work d)	ing	16b. Kind of I	Business/Ind	Justry	
7 1	ined within 72 r I Hygiene. other than "nati ent, the Medica	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		l Worker	-7		Stee	1		
ב ב	othe /ent,	BeC	17. Father's Name (First, Middle, Last					18. Mother's Name	First, Middle				
yland		To B	Herbert W. Kryg	sman				Mary Ma	argaret	Shoema	ker		
	z snould and Men is marke aumatic	-	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailin	g Address (Street	and Number or Run				Code)	
2	and 2 ealth a n 27 is ier tra		Julie Guethler/	Daughter				d, Rising				,	
<u> </u>	_ = 5 <del>5</del>		20a. Method of Disposition	-	20b. Pl		sition (Name of natory or other place		Date	20c. Location	- City or To	wn, State	
Ĕ	permit. Prages Department of I Important: If Ite any injury or o once.		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Speci</i> i		1			Gardens 6-	-29-07	Bel Ai	r Mai	rv1 and	
<u>a</u>	porta porta y inju		21. Signature of Funeral Service Licer	nsee P		22	Name and Addre	es of Facility					
ם פ	8 8 E 8		Kichard &	. Goo	die	K	T. Foar II S. Oue	rd Funeral een Street	Home,	P.A.	MD 21	1011	
			23a. art1 Enter the disea e, or com shoc, or heart failure. List only	plications hat cause	d to e death	. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,	MD Z	Approximate	
Р	hysician		Immediate Cause (Final disease or condition	Chron	716	065+	molive	Palm	1100	ny Dule	210	Onset and Death	
	/Medical		resulting in death)	a. Due to (or as				, , , ,	10	7 200		210 grs	
E	xaminer		Sequentially list conditions	b									
7	2 #	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of).							
200	and trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c									
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oo / ou,	physician and s the burial-transit	dica		d		_							
Y O	ding p	-	IF FEMALE:	00= 16.0==	-4								
2 4	certificate has been signed by the attendin rector, page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3 🗌	Ectopic pregnancy	/			ate of deliver	,	
, g	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	ath 5□	Other (specify)			101	Jitti	Day Year	
r ja	ed by detac		Part II. Other significant conditions of	ontributing to death h	ut not resul	ting in the un	derlying cause give	on in Bort I	220 Did	tahaasa uus saa	4-144441-	e cause of death?	
irec ,	signe d be	l by	Deligaral			ing in the dir	derrying cadse give	en in Fait i.	1 🗆			. 1	
5 2	peen	etec									3 Proba	ably 4 Unknown	
	has Je 2 s	Completed							24a. Was auto	psy	prior to con	osy findings available npletion of cause of	
ָר בּ	icate r, pag		12						1□ Yes	ormed? 2 <b>₩</b> No	death? 1 ☐ Yes	2□ No	
	his certificate ha	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Death				Assited	
5 8	rthis ral di	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		R/Outpatient 28b. Time of		4 U Nursing Hor				Facility	
5 5	After fune	ë	1 XNatural 5 ☐ Pending	(Month, Da		Injury	28c. Injun Work	K?	28d. Describe	how injury occur	red	1401110)	
ten S	deatl ctor: y the	ical	3 ☐ Suicide 6 ☐ Could not be		ury - At hon	ne farm stre		Yes 2 □No	Of Logation (	Canada - dat			
2	after Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	, 10, 10, 11, 51, 6	et, lactory, office		City or To	Street and Numi wn, State)	per or Hurai	Houte Number,	
Spita	neral		29a. Certifier 1 Certifying Ph	ysician: To the best	of my know	ledge, death	occurred at the tin	ne, date and place a	and due to the	cause(s) and m	annor ac et	atad	
He	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Exan	niner: On the basis o and manner sta	rexamination	on and/or inv	estigation, in my o	pinion, death occurr	ed at the time,	date and place,	and due to	the cause(s)	
To ₹	To the comp	ž	29b. Signature and title of certifier	* 4 0			29c. License	e number		29d. Date signe	d (Month, E	Day, Year)	
			Winam	, mo			D	32609		6/27	107		
5	+IVA		30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Tyge, P	rint)	10					
			Kammolm M	Ham Hy	s in	OG REN	iolulion	st ta	vreDe	Game	MD	21078	
	Stat	te	30, Name and address of person who of Kammu alm Mu 31. Date filed (Month, Day, Year)  JUN 2 8 2007	32. Registr	ar's Signatu	le facili	,						
	Registra	ar	JUN 2 8 2007	Distre	10	AND THE							

07-05187 Kenneth Kohler

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Kenneth Kohler		Sti I- For State Registrar	ate of Maryla		partment of ertificate of		and N	Mental	Hygiene	Reg. N	2.0.	17 22454
Physicia	_	Decedent's Name (First, Middl	e,Last)						2. Date of I	Death		3. Time of Death
Medical Examir	ner]	Kenneth Patrick	Kohler						Month July 5,	2007	y Year	2030 hrs
		4a. Facility Name (if not institutio Civista Medical Cente	. •	umber)	4	b. City, Towr La Plata	, or Loca	ation of D			4c. County of Dea Charles	ath
Funeral		Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1		f Under 2				Birthplace (State or
Director	ŀ	578-04-6831	X M 2 F	41	Yrs.	Months	Days	Hours	Min. Febru	uary	1,1966Wa	eign Stitungton D.C.
	[	Usual Residence of Decedent		l					1			
v any		10a. State 10b. County		10c. Cit	ty, Town or Locati	on						10d. Inside City Limits
and Shov	5	Maryland Char	les	Wa	aldorf							1 Yes 2 X No
Maryl 28a-	Θ.	10e. Street and Number				10f. Zip Coo	de		•	10g. C	Citizen of What Co	ountry?
ith the Maryland  23a or 28a-f sho notified at once.		4452 Eagle Ct.				2060	3			U	·S·A·	
h with	Funeral	11. Marital Status  1 Never Married 2 Married	cedent Ever in orces?		Decedent of Hispanic Origin? (Specify Yes or No- specify Cuban, Mexican. Puerto Rican, etc.)					erican Indian, Black,		
r deal	Never Married 2 Married 1 Yes 2 X No 1 Yes 2 X No specify:										. T.T	hito
rs afte	۵,	Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Ye or Dates:						d of work done	T161	Specify: Will b. Kind of Busines	nite s/Industry
2 hour	ted	Elementary/Secondary (0-12)		1-4 or 5+)		ost of working				100	7. Tella of basilles	Silidustry
136 thin 7 than than	휌	11		,	Genera	al Con	trac	tor	<u>a</u> (m)	S	elf Empl	oyed
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle,	Last)				18.N	Mother's N	lame (First, Midd	le, Maid	en Surname)	
121 tild be fill Mental H											rand	
	은	19a. Informant's Name/Relations									City or Town, Sta	ate, Zip Code)
2 = 5		Sonja Kohler  20a. Method of Disposition	Mother		. Place of Dispos				dorf, Mo		0603 c. Location - City	or Town State
altimore, mit. Pages I ar partment of He uportant: If ite		1 Burial 2 Cremation	3 Removal f	rom State	crematory or oth	her place) ${f J}$	uly	9,  2	007		•	
Lim Lim	ļ	4 Donation 5 Other Sa		Me	etropoli					- 1		a, Virginia
Baltimor permit. Pages Department of Important: If		21. Signature of Funeral Service	Licensee	M0066	5.8 Z2. N	iame and Add illiam	ress of I s Fu	Facility I <b>nera</b>	1 Home,	P	A. Ĥead, M	1 006/0
Physician	$\dashv$	23a. Part I. Enter the lisease, or	complications that		th. Do not enter th	e mode of dy	wtno /ing, suc	rne th as card	iac or respiratory	arrest, s	Head, M shock, or heart	d. 20640 Approximate Interval
/Medical failure. List only one cause on each line.											Between Onset and Death	
caminer		Immediate Cause (Final disease or condition resulting in death)  Drug use with complications  Due to (or as a consequence of):										
	_	Sequentially list conditions,	b									
	ine	if any, leading to immediate Due to (or as a consequence of):    Disease or injury that initiated   C.										
d d	Examiner	events resulting in death) Last	Due to (or as	a consequence	e of):							
<b>0,</b> the executed sician and burial - transit	dical	X UNPENDED	d									
30, te be e yssicia		IF FEMALE:	#23a.	27 <b>, perME</b> , outcome of pro	.g871, 9/15	5/07 TT				- Т	23d. Date of deliv	erv
787 (riffica	Z I	23b. Was decedent pregnant in the past 12 months?				tal death	3 E	Ectopic pr	egnancy		Month	Day Year
Box 68760, eath certificate be exthe attending physiciar dor use as the burial	sician/Me		TRAILE .	nant at time of	death 5 Ot	her (Specify)				ı î		9
The de by the ached f	F	Part II. Other significant condit	9 Oliki		t resulting in the u	ınderlyina caı	use giver	n in Part I	. 23e. D	id tobac	co use contribute	to the cause of death?
Division of Vital Records, P.O. tal or attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ā		v		· ·					Yes 2	No 3 P	robably 4 🗸 Unknown
ords, w requir	Completed								24a. V			autopsy findings available
e law e has l	립								_   _ p	utopsy erformed	d? death	
tal Rection: The certificate ector, page		25. Was case referred to medica				26.F	Place of I	Death (Ch	neck only one)	es 2	No 1 🗸	Yes 2 No
Vital F ysician: his certifi director,	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatient		Oth	or:	lursing Home 5	Res	idence 6 Ot	her:
n of ding Ph	<b>⊢</b> 1	27. Manner of Death	28a. Date	e of Injury th, Day,Year)	28b. Time of I	njury 28c.	Injury at	t Work?	28d. Descr	ibe how	injury occurred	
icendi leath. tor:	atie	1 X Natural 5 Pend 2 Accident Inves				1	Yes	2 No	0			
ivisi or Att after de Direct	Certification:	3 Suicide 6 Coul	d not be 28e. Pla	ce of Injury - At	t home, farm, stree	et, factory, off	ice build	ling, etc.		on (Stree		Rural Route Number, City
Division ospital or Attent hours after death meral Director:	je.	4 Homicide dete	mined (Specify	)							,	
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	ica	(Check only one) 2 ✓ Medical Exa	nysician: To the be miner:On the basis									
To t With To t	Medical	29b. Signature and title of certifie	and manner	stated.			cense nu				d. Date signed (	
		160	11-16	0/774		1	.C.M.E		OCME		uly 7, 2007	,
	ŀ	30. Name and address of person	who completed car	of death (It	em 23a)							
883		Theodore M. King, Jr.	, MD. Assist	ant Medica	l Examiner	111 Penr	Stree	t, Baltir	more, MD 21	201		
		31. Date filed (Month, Day, Year)	2007 32.	egistrar's Sign	ature dos	de						
Regist	rar	JUL 0 9	7 2001		- 7							

			1 - For Stata Registrar	State of	f Marylan	•	artment of F		and M		iene	07	22465	
			Decedent's Name (First, Middle, Las	t)						2. Date of Deat	h		3. Time of Death	
	Physici		MARJORIE M. KEN'	CON						Month JUNE	Day 14	Year 2007	4:00AM M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and nur	nber)		4b. City, Town, o	r Location o	f Death		4c. Cour	nty of Death	Till Value	
			WILLIAM HILL MAN	NOR			EAST	ON				TALBOT  9. Birthplace (State or F		
	Funeral		5. Social Security Number 6. Se		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)			
ı.	Director		219-14-4050	□M 2ÅF	82	Yrs.	Monars Days	110010		DEC 17			YLAND	
	D ≥		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	ocation					1	0d. Inside City Limits	
	sho	ž			100.01								1 □ Yes 2 X No	
	the N	Director	MD TALBO	)T		E	ASTON 10f. Zip Code			1	Oa Citizen (	of What Cour	ntry?	
	e or			7.4 D.D.				1.601					,	
	death with the Maryland ms 23e or 28a-f show Crives Le riviffled at	Funeral	10374 OLD CORDOV		dent Ever in U	.S. 13.		1601 Hispanic Orio	gin? (Spe	cify Yes or No-		SA Race - Americ	an Indian,	
	iter d	Fu	1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ☐ Yes	rces?		Was Decedent of H If Yes, specify Cub		, Puèrto F	Rican, etc.)	В	Black, White,	etc.	
38	urs al	þ	3X Widowed 4 □ Divorced	If Yes, Giv Year or D	'e		1 ☐ Yes 2 <mark>X</mark> ☐ No	Specify:			Spe	city: WH	ITE	
15-003	within 72 hours after ene. then "neturet", or ite re Medical Erainin	Completed	15. Decedent's Ed			16a. Dece	dent's Usual Occup	ation	t of working	20	16b. Kind of	b. Kind of Business/Industry		
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21	be filed ital Hygi id other event, I	Con	12	0		1	HOMEMAKEI					HOME		
nd		Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, I	Maiden Sum	name)		
<u>X</u>		၉	THOMAS W. MESSIX							OLA HOL				
Maryland 2121	2 sh and is m		19a. Informant's Name/Relationship (7			1	ng Address (Street						Code)	
	s 1 and 2 should f Health and Men item 27 is marke other treumetic		PEGGY SHORTALL/DA	NUGHIEK	20h F		CHOPTANK psition (Name of	AVE.,		-		L on - City or To	own State	
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ltimore,	t. Pag rtment rtent: I njury o		<ul> <li>4 ☐ Donation 5 ☐ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>		WO	Company of the Association Committee of the Committee of	MEMORIAI  2. Name and Addre			8/2007_	EAST(	ON, MA	RYLAND	
Bal	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.				-		FELLWOS,			N & NEW	NAM FI	JNERAL	HOME PA	
	_		23a. Part1. Enter the disease, or com	MERC								2 2160	Approximate	
Ŀ			shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line.	20 10	1	1					Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a A	or as a cons	tience off:	provavc	uter	_ ~	wenn			7045	
н	Examiner			- 1/-	105th	ville	cal	in	-1/2	1 150	a Re		Hay	
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9	e as f	Mec	IF FEMALE:	00. 11										
Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 ponths?	1 Live b	come of pregna pirth 2 Teta	al death 3	Ectopic pregnanc	у				Date of delive Month	ery Day Year	
o.	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9□ Unkn	ant at time of o	ieath 5	Other (specify)							
<u>a</u>	that the de led by the a detached	by Physician/Me	Part II. Other significant conditions of	ontributing to d	eath but not res	sulting in the t	inderlying cause giv	ven in Part I.		23e. Did to	pacco use c	contribute to t	he cause of death?	
Records,	signed d be de	ďρ	_							1 🗆 Y	s 22No	o 3 ☐ Prot	oably 4 Unknown	
Ö	w require been si should b	ete								24a. Was a	n 24	th Were auto	ppsy findings available	
Re	ne lav has ge 2 g	Completed								autops perfori	med?	prior to co death?	mpletion of cause of	
	icien: Th certificate rector, pag		25. Was case referred to medical					OF Place	of Dogth	1 ☐ Yes	2₽No	1 🗆 Yes	2 No	
₹	sicie s certi lirecto	o Be	examiner?	Hospital:	Inpatient 2	ER/Outpatie	nt 3□ DOA Ott	-		me 5 Reside		Other (Specia	(v)	
o	g Phys er this eral di	n: To	27. Maprier of Death	28a, Date		28b. Time o				28d. Describe h			,,	
ion	Attending Physicien: r death. ector: After this certifica by the funeral director, I	atlo	Natural 5 ☐ Pending 2 ☐ Accident investigation		in, Day 1 ear)	Injury		Yes 2	No					
Division of Vital	I or Attendater deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place	of Injury - At h	iome, farm, st	reet, factory, office		1	28f. Location (S City or Town		ımbər or Run	al Route Number,	
	tel or A	Cer		4										
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier f Certifying Ph				th occurred at the ti							
	To the Hi within 24 To the Fi completed	Medical	one)		ner stated.		29c. Licens					gned (Month,		
	To Will	<	29b. Signature and title of certifier		MD			5-75	0		6-16		7	
•			Mag	7	,			- , 0			- '	- /		
	6		30. Name and address of person who					TP A CIPE	ON T	MD 2162	ı			
	Sta	ite	ROBERT B. SANC		D. 508 tegistrar's Sign		LLD AVE.,	LAST	UN,	м 216U.				
	Regist		JUN 1 5 20											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Russell Leon Kinnamon 10:55 pM June 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5729 Ross Neck Road Cambridge Dorchester 5. Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 12 M 2 □ F Days Hours Yrs 215-62-0747 Director 53 1953 14, Dec. Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at MD Director Dorchester 1 ☐ Yes 2 ☐ No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5729 Ross Neck Road 21613 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Mayes 2 No
If Yes, Give
Year or Dates: 1973–97 1 Never Married 2 Married 1 ☐ Yes 2 █ No Specify: ģ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the supervisor state government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental F Be 27 is marked of traumatic even Russell Leon Kinnamon 1 and 2 should Sylvia Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Eydie Kinnamon wife 5729 Ross Neck Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation , 5 □ Other (Specify) Maryland Veterans Cem. 6/29/07 Hurlock, MD 21. Signature of geral Service Ligensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancreatic months /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 Probably 4 □Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Jas autonsy perform certificate 2 J 1□ Yes Physician: 25. Was case referred to edical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes Certification: To 1 | Inpatient 2 ER/Outpatient 3 DOA this 6 ☐Other (Specify) 27. Manner Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending (Month, Day Year) 1 atural Injury 5 | Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Mary Ann D.

31. Date filed (Month, Day,

Moore,

Year)

M.D.

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

300 Dorchester Ave., Cambridge,

MD

21613

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EVERNA -IVINE DUNPUSP If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🔀 F 208-05-7123 Director 91 Sep. 8, 1915 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County ns 23a or 28a-f shov must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 ☑ No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 McKinsey Road 21146 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No White Specify Completed by 3 X Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aircraft than Elementary/Secondary (0-12) College (1-4or 5+) 12 Manufactuers Riveter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked Robert B. Lyman Nellie Shontz ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Werner/Niece 27 104 Evergreen Road, Severna Park, MD June 23, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State Bigler Cemetery Clearfield, PA 4 Donation 5 Dother (Specify) 2007 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Fuenral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PVANCED Physician DOMONTA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): burial-t ng physician as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 ☐ Fetal death 3 ☐ Ectopic pregnancy for Day Year signed by the a 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? A5515100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA LIVENG 27. Mann | Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide determined within 24 hours aft

To the Funeral D

completely filled in To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 046360 ath (Item 23a) (Type, Print) 1 Vorgerm HIGHWAY MILLERSVILLE MD 21108 31 Date filed (Month, Day, Year) State JULY 2 6 2007 Registrar

State of Manyland / Donartmont of Hoalth and Montal Hygiono

		•	1 - State Of IVIa	Ce	rtificate of			eg. No. 200	1 22:53	
y .	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Year	3. Time of Death	
/Medi Examii		al	Dorothy Knopfer  4a. Facility Name (If not institution, give street and number)		Ab City Town o	r Location of Death	June	25, 2007 4c. County of Dea	3:00 P. M	
		er	11400 Strand Drive, # 402		Rockvi			Montgomery		
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1	93 Yrs.	s. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			reard 1913 Ne	irthplace (State or Foreign County) WYOrk	
Daitiiille e, inai yiaila e le 13-0030	and w.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit							
	Maryl. f sho	to	Maryland Montgomery Rockville X□Yes 2□No						1XTYes 2 □ No	
	th the	irec	10e. Street and Number		10f. Zip Code		10	Og. Citizen of What C		
	23a c	ral	11400 Strand Drive, # 402		208			U. S. A		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Yes 2 W If Yes, Give Year or Dates:	iver in U.S. 13.	Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:		
	72 ho natur dical I	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup e kind of work done	oation during most of work d)	ing	16b. Kind of Busines	s/Industry	
	vithin ane. Ihan " ie Me	Completed	Elementary/Secondary (0-12) College (1-4or 5	+)	<i>DO NOT use retire</i> emaker	d)		Own Home		
	filed \ Hygie ther t	ပ္ပိ	17. Father's Name (First, Middle, Last)	110111	CIIIAKCI	18. Mother's Name	e (First, Middle, N			
	lid be lental <b>ked o</b> Ic eve	To Be	Boris Bizer			Rebecc	a Gorel	ick		
	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						, Zip Code)	
	and 2 ealth n 27 I	,	Joan A. Eisner - Daughter						aryland 20852	
	Pages 1 ment of H ant: If iten		20a. Method of Disposition  1X Burial 2 □ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify)	King Dav		dns   6/27	/2007 F		ch, Virginia	
Dag	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee	nuch	1170 Rock	ville Pik	e, Rocky	al Chapels ville, Mar		
	Physician /Medical Examiner	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):								
Division of vital necodas, r.O. Box 00700,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Or the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a consequence of):						
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	lelivery Day Year	
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Peripheral Vascular Disease					23e. Did tobacco use contribute to the cause of death?  1  Yes  No 3 Probably 4 Unknown		
		Completed by					24a. Was a autops perform	y prior to ned? death	autopsy findings available occupietion of cause of ?	
		Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)							
	Physic this c	스	1   Yes 2 1 No						pecify)	
	ding Ih. : After : funer	tion:	1 I Matural 5 □ Pending (Month, Day 2 □ Accident investigation	of 28c. Injury at 28 Work?  M 1 ☐ Yes 2 ☐ No		28d. Describe no	od. Describe now injury decurred			
	al or Atter after dea I Director d in by the	Certification:	6 Could not be	y - At home, farm, street, factory, office (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical C	29a. Certifier  (Check only one)  1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To th Within To th COMP	Me	29b. Signature and title of certifie 29c. License number					29d. Date signed (Month, Day, Year)		
	/-		D36797					June 26, 2007		
	$\omega$		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Alan R. Sheff 10215 Fernwood Road, Bethesda, Maryland 20817							
	Sta Registi		JUN 2 7 2007	ar's Signature	fores					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2007 1:30 P M June 22, Janet Louise King /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 📉 F 9, Pennsylvania 71 1936 Director 164-30-2195 Feb. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 1 No Director PA Centre Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö items 23a 2214 Old 220 Road 16814 USA Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō, 1 ☐ Yes 2 No Specify Specify: White ģ 3 Widowed 4 Divorced 'natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth E. Houser Gladys Billett ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12244 Quince Valley Dr., North Potomac, MD 20878 Belinda O'Berry / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory June 26, 2007 | Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, T. 500 University Blvd. West, Silver

23a. Part, Anter the dielease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Francis J. Collins Funeral Home, Inc. 500 University Blvd. West, Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Intracranial Hemorrhage /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequance of): Examine or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence attending physician Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetai dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month 5 Other (specify) I ☐ Yes 2 🖾 No 9 Hinknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No s after death.

I Director: After this conditions of the funeral director. 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 6/20/2007 1 Natural 5 Pending investigation Fall 11:00 PM 1 ☐ Yes 2 TXNo 2 X Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4301 Knowles Avenue determined 4 ☐ Homicide nursing home facility To the Hospital within 24 hours a To the Funeral C Kensington, MD 20895 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

A manner stated.

State

Registrar

29b. Signature and fitte of certifier

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

P M.D., 5530 Wisconsin Avenue, #1208, Chevy Chase, MD 20815 Jeffrey Muench, 31. Date filed (Month, Day, Year) JUN 2 7 2007

s of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 57591

29d. Date signed (Month. Dav. Year)

June 24, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:22 P M Barbara Kettler-Mills June 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 1014 Penny Drive Stevensville Queen Anne's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🝊 F 578-22-9063 82 Director 09/02/1924 Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10a State 10b. County 1
▼Yes 2 No Directo Maryland Queen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 1014 Penny Drive 21666 ral", or Items 23a Examiner must b United States Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 X Widowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental and Mental James Forest Walker Sr. Marie Louise McCabe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 Is any Injury or other traionce. Robert C. Kettler / Son 600 Boyle Ln. Mclean, VA 22102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 06/29/2007 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 90/23/2007 Massituation, 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) onchogenic caucinoma **Physician** 2 MOJ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 BR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide or To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and Mile of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year) JUN 27 20

SCIONICU, WO
32 gistrar's Signature
7 2007

400

Bestgate Ru. Annapolis, Md. 2140

			State of Maryland / Department of Health a 1- State Registrar Certificate of Death		ntal Hygier Reg. <i>t</i>	21117	221.71					
d	Physicia	an	1. Decedent's Name (First, Middle, Last)  Joseph Dudley Lacey, Sr.		Date of Death	Day Year 2007	3. Time of Death 6:30 P M					
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of			1 ZUU / 4c. County of Deat						
		2	24487 Ruff Ruff Lane Hollywo  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 1		Date of Pirth	St. M	ary's hplace (State or Foreign					
	Funeral Director		214-42-4614  1 M 2 F 62 Yrs. Months Days Hours	Min. Jı	Date of Birth (Month, Day, Yea une 21,	1945 M	untry) aryland					
	land bw ut		Usual Residence of Decedent  10a. State				10d. Inside City Limits					
	e Mary 3a-f shu tified a	Director	Maryland St. Mary's Holly	wood			1 □Yes 2 No					
	with the		106. Street and Number 10f. Zip Code 24487 Ruff Ruff Lane 20636	6	10g. (	Citizen of What Co USA	untry?					
٥	be filed within 72 hours after death with the Maryland ttal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In Specify: 1 Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No	igin? (Specify in, Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, White						
215-0036	n 72 hours 1 "natural", ledical Exa	Completed by	3   Wildowed   4   Divorced   Year or Dates:		Ī	Kind of Business/	11					
717	ed withi	Comp	Elementary/Secondary (U-12) College (1-40r S+) Plumber			JS Govern	ment					
and	~ = 0 %	Be	17. Father's Name (First, Middle, Last) William Dudley Lacey	er's Name <i>(Fi</i>	irst, Middle, Maid Marv El	<sub>len Surname)</sub> Lsie Knot	t					
Mary	2 shoul and M Is marl aumati	ဥ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number		oute Number, Cit	y or Town, State, 2	ip Code)					
ნ. _	1 and Health tem 27		Frances Weeks Lacey / Wife 24487 Ruff Ruff La:  20a. Method of Disposition   20b. Place of Disposition (Name of	ne Ho		, MD 2063						
saitimore,	Pages ment of ant: If It ury or o		1 图 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	July 5	007 Но	llywood,	Maryland					
Dail	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic en once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 270 Lev		ngley-Gard wn, MD 206		al Home, P.A.					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death					
	Physician /Medical		disease or condition resulting in death)  a.   Lun Can Stuly  Due to (or as a persequence of):	cm	etusta	515						
	Examiner	-e	Sequentially list conditions,  Due to or as a conse uence of:	Sequentially list conditions, if any locating to immediate cause. Enter Underlying.  Due to [or as a consequence of]:								
	acuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.									
8/60,	ficate be executed physician and is the burial-transit	dical Ex	Due to (or as a consequence of):									
٥	ertificate ing phy e as the	Medic	IF FEMALE:									
.c. Box	w requires that the death certific been signed by the attending f should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1			23d. Date of del Month	very Day Year					
cords, P.	quires that to signed by	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	I.			the cause of death?					
ris .	10 to 10	completed			24a. Was an autopsy performed 1 Yes 2 ♣	prior to o	topsy findings available completion of cause of					
Z	iclan: certifica ector, p	BeC	examiner?		heck only one)							
101	ig Phys ter this neral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		5 sesidence Describe how in	6 ☐Other (Specialist)	cify)					
UIVISION	ttendin death. stor: Aff	ertification:	2 Accident investigation M 1 Yes 2 1		Landing (Chroni		The state of the s					
2	s after al Direct al Direc	Certif	4 Homicide determined building, etc. (Specify)	201.	City or Town, St	and Number or Ru ate)	rai Houte Number,					
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	edical	29a. Certifier (Check only one)  **Descripting Physician: To the best of my knowledge, death occurred at the time, date an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.	nd place, and ath occurred	due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)					
	vithi To t	Ž	29b. Signature and title of certifier  29c. License number	13	29d. I	Date signed (Monti						
1	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen Bauer,			7/2/20	07					
	10		28103 Three Notch Road, Ste 101 Mechanicsville, MD 20659									
	Sta Registra		31. Date filed (Month, Day, Year)  JUL 0 3 2007									

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

attending physician signed by t certificate this After after death filled in by the within 24 hours a To the Funeral L Hospital

1.X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06/30/ 07

1-10+1

Tu Bui MD 1138 Opal Ct. 31. Date filed (Month, Day, Year) State JUL 0 8

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstuwn, MD

Registrar

		ļ	State of Maryland / De State of Maryland / De Registrar	epartment of Health a Certificate of Death	and Mental H	lygiene Reg. No.2007	22573
* <u>.</u>	Physici		Decedent's Name (First, Middle, Last)     Eric Lawrence		2. Date of Month	Death 24 / 2007	3. Time of Death 7:11P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Silver Spri	of Death	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 104-20-2226 1 M 2 F 88 Yr	Months Days Hours		Birth 9. Bir Day, Year) Don	thplace (State or Foreign ountry) ninica
	ie Maryland Ba-f show tified at	ctor		ver Spring			10d. Inside City Limits 1 Yes 2 No
	h with th 3a or 28 st be no	al Dire	10e. Street and Number 1618 Ingram Terrace	10f. Zip Code 20906		10g. Citizen of What Co	ountry?
036	be filed within 72 hours after death with the Maryland rial Hygiene. 3d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	<ul> <li>13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexical</li> <li>1 ☐ Yes 2 No Specify:</li> </ul>		No- 14. Race - Ame Black, Whi Specify: B1a	te, etc.
21215-0036	filed within 72 ho Hygiene. wher than "natur: ent, the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during mos life. DO NOT use retired) Banker	at of working	16b. Kind of Business Private	/Industry
and	id be filed ental Hyg ked other ic event, i	To Be C	17. Father's Name (First, Middle, Last)  James Lawrence		er's Name <i>(First, Mid</i> cille Gard	dle, Maiden Surname) lier	
Mary	nd 2 shou lith and M 27 Is mar r traumati	-	19a. Informant's Name/Relationship (Type. Print) Mary A. Lawrence/ Daughter 161	Nailing Address (Street and Number 8 Ingram Terr	er or Rural Route Nu ace Silv	mber, City or Town, State, ver Spring, N	Zip Code) ID 20906
saitimore,	ages 1 ar int of Hea t: If Item :		1 ☐Burial 2 ☐Cremation 3 ☐Removal from State cemetery,	Disposition (Name of crematory or other place)	Date	20c. Location - City or	
Baitil	permit. Pages 1 and 2 should be fo Department of Health and Mental I Important: If Item 27 Is marked of any injury or other traumatic even once.		4 □ Donation 5 □ Other (Specify) Gate of  21. Signature of Funeral Species Licensee	22. Name and Address of Facility 7474 Landover			Home
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Acute Myocardi  Due to (or as a consequence of)	al Infarction	cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death minutes
9/00,	cate be executed by sician and the burial-transit but	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Coronary Arter  Lus to (or as a consequence of)  Due to (or as a consequence of)	y Disease			years
O. Box 68	eath certifi attending   for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	blivery Day Year
ds, r	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I		id tobacco use contribute t	o the cause of death?
al Kecord	The lar	Completed			į pe	das an 24b. Were a prior to death? s 2 ✓ No 1 ☐ Ye	utopsy findings available completion of cause of
r vital	ıysician iis certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1   Inpatient 2 PER/Outp	Othor	e of Death <i>(Check on</i> ursing Home 5 ☐ R	ly one) esidence 6 □Other (Spe	ecify)
0 00	inding Ph ath. ir: After the		27. Manner of Death 1			be how injury occurred	
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, to the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	ı, street, factory, office	28f. Locatio City or	n (Street and Number or F Town, State)	dural Route Number,
	e Hospit 24 hour e Funera letely fille	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, on the basis of examination and/and manner, etaled.				
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
	16	9	Name and address of person who completed cause of death (Item 23a) (Ty	D64008  ype, Print)		6/24/2007	
U '	Sta			500 Forest Glen	RD. Silv	er Spring, N	D 20910
	Sta Registr		31. Date filed (Month, Ray, Year)  32. Registrar's Synature  33. Registrar's Synature				

			1 - For State Registrar	State of M	aryland /	Departmo Certific			Mental Hy	giene ()	pathod are	2247
	Physici /Medi			hia Liang					2. Date of De Month June	26,200	Year 7	3. Time of Death 1:42A M
	Examir	ner	4a. Facility Name (If not institution, g National L			4b. C	_	Location of Dea	th	4c. County		ry
A	Funeral Director	7	453-79-5791	Sex 1 X M 2 ☐ F	e (In yrs. last bi		der 1 Year hs Days	If Under 24 Hr. Hours Min	8. Date of Bi (Month, Day May 2	th ay, Year) 6,1916	9. Birthr Cour Ch	oface (State or Foreign vtry) 1 n a
	Maryland -f ehow	tor	Usual Residence of Decedent   10a. State   10b. County   Md •   Montge	omery	10c. City, Tov	vn or Location Ro	ckvi1	.le			1	10d. Inside City Limits 1. Yes 2 □ No
	h with the	al Director	10e. Street and Number 9701 - Veirs	Drive	1	10f.	Zip Code 208	50		10g. Citizen of V		ntry?
336	within 72 hours after death with the Maryland ane. then "naturel", or Items 23a or 28a-f ehow he Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	Ever in U.S.		cedent of Hi pecify Cuba	spanic Origin? (i n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify	k, White,	can Indian, etc. ninese
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-1 ehow eny injury or other treumatic event, the Medical Exeminar must be notified at once.	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	l Education		a. Decedent's U (Give kind of life. DO NO	work done a Tuse retired,	urina most of wo	orking	16b. Kind of Bi		
land 2	should be filed and Mental Hygi s markad other umatic evant,	To Be Co	17. Father's Name (First, Middle, Las Cheng Chi	t)					me (First, Middle h Chen	, Maiden Surnarr	re)	
	nd 2 shou lith and M 27 is mar r treumst	-	19a. Informant's Name/Relationship Richard Liang-			b. Mailing Addn 5 Lock	ess (Street a	nd Number or R nd Cou	rt, Poto	er, City or Town,	State, Zip	Code) 0854
Baltimore,	Pages 1 a nent of Hea int: if item iry or othe		20a. Method of Disposition  1  Burial 2  Cremation 3 (4  Donation 5  Other (Specific Property of the Company)	☐Removal from State	20b. Place of cemeter Metrop	of Disposition (f ory, crematory of olitar	Name of or other place	matory	Date -6/27/0	20c. Location -	City or To	wn, State
Balt	permit. Departn Imports eny injt		21. Signature of Funeral Service kits	A Moran			and Addres	s of Facility		22-Wisc shingto		in Ave.,N
68/60,	Compared to the process of the private of the priva	edical Examiner	23a. Part1. Enter the disease or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. NETA  Due to (or as  b. ACUT  Due to (or as	GOL) C	AC of): of): ALT-	100 SI		o or respiratory a	d -		Approximate Interval Between Onset and Death
O. Box 6	death certif e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopio 5 □ Other				23d. Dat Mor	e of delive	ory Day Year
ecords, P.	requires that the een signed by th hould be detache	þ	Part fl. Other significant conditions	contributing to death bu	ut not resulting i	n the underlying	g cause give	n in Part I.				ne cause of death?
ב	The lar	Completed							24a. Was autor perio 1 Yes	rmed?	Vere autorior to cor leath?	psy findings available appletion of cause of 2 \square No
<b>X</b>	Physician: The this certificate al director, pag	o Be	25. Was case referred to medicaf examiner?  1 ☐ Yes 2 ⋈ No	Hospital:	nt 2□ER/Ou	utpatient 3	Other		ath <i>(Check only c</i> Home 5 ☐ Resid			
0 10	nding Ph ath. r: After th e funeral	atlon: T	27. Manner of Death  1. ☐ Naturaf 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b.	Time of njury	28c. Injury Work			now injury occurr		7
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificity the Funeral Director, gompletely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		ry - At home, fa . (Specify)	ırm, street, fact	ory, office		28f. Location (S City or Tov	Street and Number vn, State)	er or Rura	Route Number,
	in 24 house in 24 hour the Funer ipletely fil	edical	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination an	e, death occurre d/or investigation	ed at the time on, in my opi	e, date and place nion, death occu	e, and due to the urred at the time,	cause(s) and maddate and place, a	nner as st and due to	ated. the cause(s)
	To	Σ	29b. Signature and title of certifier	why	11.0	2	9c. License	number 5 / 1 5 8		29d. Date signed	(Month, I	
(	10		30. Name and address of person who			(Type, Print)					26	2007
6	Sta	e	VATTI ANTHONY  31. Date filed (Month, Day, Year)	976) 32. Registra	VEIPS r's Signature	DRIVE	(2	Lockuli	- L E	Mo 2	085	0
	Registra	ar	31. Date filed (Month, Day, Year) JUN-2 8 2007	A	A 1	10						

07-05191 Jeffrey Lieberman

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te of Maryland / Department of Health and Mental Hygiene	2007	2211
Certificate of Death		

		1- For State Registrar	-	Certif	ficate of	Death		•	Re	g. <b>N</b> o.		B III Nov. Horsel S F
Physic		ian/ 1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year										
lerical Exan	nıner	Mark			eberma	n City, Town,		f Dooth	July 6, 200	7 4c. County	of Dooth	
		4a. Facility Name (if not institution, g 9817 Bristol Square lane			41	Bethesda	or Location of	Death		Montgo		'
Funera	1	Social Security Number 6.3	Sex 7. Age	e (In yrs. last	birthday)	If Under 1 Ye		r 24Hrs.	8. Date of Birt	n(MM/DD/YYY		thplace (State or
Directo	r	145-60-2632	X м 2 F	40	Yrs.	Months Da	ays Hours	. Min.	July 5	1967	Co	on New York
	p. 11 1 1	Usual Residence of Decedent  10a, State 10b, County		10c City To	own or Location	n						10d. Inside City Limits
ow any		Maryland Montgom	0.27	Bethe		11						1 Yes 2 X No
Maryland 28a-f show	턍	10e. Street and Number	ЕГУ	Detile	Sua	10f. Zip Code		-		g. Citizen of W	/hat Cou	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f should it would be Medical Franciner must be notified at one	Director	9817 Bristol Squ	are Lane.	#201		2081			τ	Jnited	Stat	es
with 1	eral	11. Marital Status	12. Was Decedent	Ever in U.S.					cify Yes or No-			ican Indian, Black,
death or item	Fun	1 X Never Married 2 Marrie	1 Yes 2	X No		s, specify Cub		Puerto R	ican, etc.)		te, etc.	
s after	þ		ed If Yes, Give Year or Dates:		LJ	Yes 2 X N		in d of	u. d	Specify.		ite
11215-0036 Id be filed within 72 hours after Aental Hygiene Aente of the man "natural",	ted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or		6a. Decedent' during mo	s Osual Occup st of working li				16b. Kind of E	susmess/	industry
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		or condition resulting in death)	Due to (or as a conse	equence of):								
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Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical		ner: On the basis of exa and manner stated.	mination and	/or investigation			curred at	the time, date			
	Σ	29b. Signature and title of certifier	e A	7			nse number					onth, Day, Year)
94		laval	(/ (	,		0.0	C.M.E.			July 7, 20		
		30. Name and address of person wh Zabiullah Ali, M.D. As	io completed cause of c sistant Medical Ex			Street, Ba	altimore, N	MD 212	:01			
	State		32 Registra	r's Signature								
	istrai		JULY SERVE	ic s	Sec	1		OC.	ME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 09:45 am Irene Rehill Moore 2007 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Hospital of Cecil
5. Social Security Number | 6. Sex Cecil E1kton If Under 1 Year County 8. Date of Birth (Month, Day, Year) Aug. 6, 1922 If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Hours Min Months Maryland 219-12-6853 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes XXNo Director Maryland Cecil Rising Sun 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21911 1881 Telegraph Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) marked other than Elementary/Secondary (0-12) Accountant Government injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked o <u>John Wallace Rehill</u> Louise Liebig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Frint) Janet Connon / Friend 5 Colonial Circle, North East, Maryland 21901 20a. Method of Disposition

1★★Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State June 4 ☐ Donation 5 ☐ Other (Specify) 29,2007 St. Mary Anne's Cem. North East, Maryland 21. Signatur of yner pervice lice 22. Name and Address of Facility Crouch Funeral Home any 127 South Main Street, North East, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 deur **Physician** nuclen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last meumon Directo (or each normed Henrich of): Examiner death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the and the funeral birector. After this certificate has been signed by the analysis in his the funeral director, page 2 should be detached. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tyes reidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□ Yes & 1 ☐ Yes 2 No RE No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manper of Death 28d. Describe how injury occurred Medical Certification: Injury **≯** □ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 63730

State Registrar NAMITA TULI, LINION
31. Date filed (Month, Day, Year) 9 2007
32. Highstrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOSPITAL, ELILTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2007 P M 6:23 R. 26 James Manard June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington 1627 Hoffmaster Road Knoxville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1 X M 2 □ F Washington, DC 219-54-5474 Oct. 8, 1949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Knoxville Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1627 Hoffmaster Road 21758 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Joseph Manard Barbara Jean Burdis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise D. Manard / Wife 1627 Hoffmaster Road Knoxville, Maryland 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 30 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 2007 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, PA. 21. Signature of Funeral Stryice Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cruse on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Unowho Due to (or as 4 consequence of): Sequentially list conditions, if any, leading to inmodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 → res 2 No 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify)

**Physician** /Medical **Examiner** law requires that the death certificate be executed

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-transi and physician the ! as attending esn ed by the a signed to page 2 should peen certificate has

Examiner Physician/Medical þ Completed funeral director, this After t 24 hours after death Prineral Director; filled in by the

Division or Vital Records, P.O. Box 68760,

1 ☐ Yes 2 40 27. Manner eath

1 Mutural

2 Accident

3 Suicide

4 Homicide

(Check only one)

29b. Signatur

Be ၉ Certification: 29a. Certifier Medical

Hospital or Attending

death.

State Registrar

DHMH 17 Rev 1/2001

sompletely

within 2

31. Date filed (Month 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

and title of certifier

GASS 110

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

11110 Mede

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		ar yraria	-	rtificate				-	Reg. No.	_ U ! /		221	1/5
ge Ber	Physici	an	1. Decedent's Name (First, Middle, La							2	. Date of De Month	eath Day	Yea	ır	3. Time of	
2 - E	/Medi		Thomas Franci								June	30	200		3:18	A M
	Examir	ier	4a. Facility Name (If not institution, given 19222 Nelson Cour				4b. City, Val1		Location	of Death		1	County of De			
	Funeral				je (In yrs. las	st birthday)	If Under	1 Year	If Under		. Date of Bir	th	t. Mar	irthpl	ace (State	or Foreign
for '	Director	г	200-30-7304	1 <b>∑</b> M 2□F	54	Yrs.	Months	Days	Hours	Min.	(Month, Da 19/30/		-!	Couint hic	try)	
and	w t		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation	_						10	Od. Inside (	City Limits
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ar dea	tems er mu	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Deced	lent of Hi cify Cuba	spanic Or n, Mexica	igin? (Specit n, Puerto Ri	fy Yes or No can, etc.)	)-	14. Race - Ar Black, WI			
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland	it of Health and Mental Hyglene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 ☐ Yes 2		Specify:				Specify: W			
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ary shou	and M Is mar aumat		19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street a					r Town, State	, Zip	Code)	
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altimore, mit. Pages 1 ar	of He		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐	Removal from State	20b. Plac	ce of Dispo netery, cren	sition (Nam natory or o	ne of ther place	e) :	July Dat			cation - City			
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Ball	Department of Important: If it any injury or conce.		21. Signature of Funeral Service Lice	/7/4	1	-	. Name and			DITI			neral			.A.
م م			Kyle S. Simons		d Also also also				_				own, M	D 2		
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	ysician Medical		disease or condition resulting in death)	a. META	4		ENA		1500	CHC				-	1691	es.
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Or Vita Physician:	.ഈ ರ	To B	examiner? 1 ☐ Yes  2☐ No	Hospital: 1 ☐ Inpatie	ent 2□EF	l/Outpatien	t 3 🗆 DO.	A Othe	r.				Other (Sp	pecify	)	
2 E	h. After th funeral		27. Manner of Death  1 ☐ Matural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28 y Year)	Bb. Time of Injury	28	8c. Injury Work	at ?	280	d. Describe	how injury	occurred /			
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he Ho	he Fu	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	t examınatioi	n and/or in\ 	estigation,	in my op	oinion, dea	ath occurred	at the time,	date and	place, and d	ue to	the cause(	(s)
Tot	To the complete	Σ	29b. Signature and title of certifier	ì		12	29c.	License					e signed (Mo.		ay, Year)	
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			30. Name and address of person who		eath (Item 23	3a) (Type, F	1757	1 45	SOC1.	ATES	,1100	ywo	062	N	4	
*	Sta	_	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur											
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2017

			1 - For State Registrar	State of Ma	-		ite of Dea			Rag. No.		to to the				
			Decedent's Name (First, Middle, Last	t)					2. Date of Dea	ath	V	3. Time of Death				
	Physici /Medio		Evelyn Marie MCC	LANATHAN					June 2	9, <sup>Day</sup>	)07	5:50 a. <sup>M</sup>				
	Examir		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or Local	tion of Death		4c. (	County of Death					
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5/4	Funeral Director		217-28-0962	ox 7. Age □M 2⊠F	(In yrs. last bir	Yrs. If Unc Month		nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da Nov. 8			place (State or Foreign intry) yland				
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits				
	Maryli Febo	ö										11√2 Yes 2 □ No				
	28a-	Director	Maryland Washing 10e. Street and Number	ton	Hager	stown	Zip Code			10g. Citiz	en of What Cou	untry?				
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	death ms 2	nera	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec	edent of Hispani pecify Cuban, Me		ecity Yes or No	- 1	4. Race - Amer					
21215-0036	within 72 hours after death with the Maryland ane than "natural", or Items 23a or 28a-f ehow the Madigal Examirat must be notified at	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	lo		2  No Spe		Hican, etc.)		Black, White Specify: Wh	ite				
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yla	i Men Men Marke Marke	10	George M. Bowers						C. A. M							
Maryland	12 st h and 7 le n traun		19a. Informant's Name/Relationship				ss (Street and No									
	1 and Healt am 2		Marsha Stotelmyer 20a. Method of Disposition	-Granddaug		Disposition (A ry, crematory o			et, nag Date		ation - City or T					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23a or 28a-f ehow wall fujury or other traumatic event, the Madical Examinatinat must be notified at anose.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		1		rother place) rematory	7/1	/07		•	, Maryland				
Ball	permit Depart Import eny In		21. Signature of Funeral Service Licen	Pare kin			and Address of F  Wilsor		MINNICH , Hager			ME land 21740				
			23a. Part1. Enter the disease, or company shock or heart failure. List only	olications that caused	the death. Do							Approximate				
	Physician		Immediate Cause (Final disease or condition	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death												
	/Medical	ĺ	resulting in death)	Due to (or as a	consequence		•									
н	Examiner		Sequentially list conditions.	b												
	pe #s	ine	Sequentially list conditions, if any, leading to him addate cause. Enter Underlying Cause (Disease or injury that initiated events	Oua to (or as a	s consequence	Ut)-										
_	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	a consequence	of):										
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner		ď	·	•										
	tificat ig phy as th															
.O. Box	death cer e attendir id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 □Ectopic 5 □ Other (				2	3d. Date of deli Month	very Day Year				
٥.	res that t igned by be detac		Part II. Other significant conditions c	ontributing to death bu	it not resulting in	n the underlying	cause given in F	Part I.	23e. Did to	obacco us	se contribute to	the cause of death?				
Records,	quires n sign ald be	q p	camo sate	Dine	n Hos	enter	nia		101	∕es 2□	No 3□Pro	bably 4 Hinnown				
Ö	s been si should	lete	nopulipidemia	regrettore	The o	Seim	n Duna	lu	24a. Was	an	24b. Were aut	opsy findings available				
R	Physician: The law requires that the this certificate hes been signed by the tal director, page 2 should be detached.	Completed by								rmed? 2 4 No	death?	ompletion of cause of 2 ☐ No				
Vital	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?	-					h (Check only o	ne)						
of V	hysic his ce Il dire	2	1 Yes 2 10	Hospital: 1 Inpatie		itpatient 3	DOA Other: 4[	☐ Nursing Ho	me 5 A Resid	dence 6	□Other (Spec	ıfy)				
Ē	ding P h. After t funera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of njury	28c. Injury at Work?		28d. Describe h	now injury	occurred					
Sio	Attending r death. ector: After y the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	-	411	M	1 Tes		00/ 1 //							
Division	tal or Al	Certif	4 Homicide determined	28e. Place of Inju- building, etc	ry - At nome, ra :. (Specify)	irm, street, fact	ory, office		City or Tox			ral Route Number,				
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical Certification:	29a. Certifier (Check only one)	ysician: To the best on niner: On the basis of and manner sta	examination an	e, death occurre d/or investigati	ed at the time, dai	te and place, death occur	and due to the red at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)				
	To th withir To th comp	ž	29b. Signature and title of certifier			2	9c. License num				signed (Month					
			- British	W.			0(801	9		JUN	E 29.	2007				
_ Ł	11-2		30. Name and address of person who		eath (Item 23a)	(Type, Print)	sa H	A 6 5A	25-70 W	~	mo:	21740				
2	H-7		31. Date filed (Month, Day, Year)				- ` ` `									
	Sta Registr		JUL 0 2	2007	r's Signature	Sperk	2									

			For State Registrar	State	of Marylar		artment of I <i>rtificate of</i>		d Mental H	ygiene Reg. No.	17 17	221:80
	Physici /Medic		1. Decedent's Name (First, Middle, La.  Helen Elizabeth	,	hael				2. Date of E Month June	Death Day 24,	200 <sup>Year</sup>	3. Time of Death 7:30 P M
	Examin		4a. Facility Name (If not institution, give	e street and n	umber)		4b. City, Town, o		Peath	4c.	County of Death	
	Funeral Director		Social Security Number 6. S		7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of B (Month, L 1-23-1	Sirth Day, Year)	Cou	place (State or Foreign ntry) ington, DC
	Maryland f show led at	or	Usual Residence of Decedent  10a. State 10b. County  MD Montgome	ry		ty, Town or Lo			•			10d. Inside City Limits 1
	with the I a or 28a- be notif	Direct	10e. Street and Number 15721 Allnut Lar	ıe		4	10f. Zip Code 208	66			zen of What Cou	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed F	2 XNo ilve				? (Specify Yes or Nuerto Rican, etc.)		14. Race - Ameri Black, White Specify: Wh	can Indian, , etc.
21215-0036	l within 72 hou liene, r than "natura the Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed	) (1-4or 5+)	16a. Deced (Give life. Bookke	dent's Usual Occu kind of work done DO NOT use retire	oation during most of d)	working		nd of Business/Ir	•
z pue	l be filed ntal Hyg ed other event, t	Be	17. Father's Name (First, Middle, Last, Howard B. Carrol			1200			Name (First, Middle Cunningh	le, Maiden		
Maryland	12 should h and Mei 7 is marke traumatic	To	19a. Informant's Name/Relationship ( Karen Griscom/ Da	Type. Print)				and Number o	or Rural Route Num evensvill	ber, City o		p Code)
altimore, I	Pages 1 and ment of Healt ant; If Item 2 ary or other		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the content	Removal fron	20b.	Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date 6-27-2007	20c. Lo	ocation - City or T	MD
Balt	permit. Departi Importa any inj		21. Signature of Funeral Serves Lice	isee		34	2. Name and Addre	ess of Facility ensburg	Fort Line Road E	oln l Srentv	runeral wood, MD	Home 20722
	Physician	53	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Card	iac Arr	hythmia		ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions,	Caro	inoma							1 Month
	and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Coro	nary Ar	tery I	Disease					5 Years
58760,	ficate be executed physician and sthe burial-transit	dical E			rlipemi							
O. Box 6	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 ☐Live	utcome pf pregn birth 2□Fet gnant at time of nown	al death 3	Ectopic pregnand Other <i>(specify)</i>	у	_		23d. Date of deliv	very Day Year
٦.	requires that the een signed by th nould be detache	by	Part II. Other significant conditions of Alzheimer's Dise	•	death but not re	sulting in the u	nderlying cause gi	ven in Part I.		•	7	the cause of death?
Vital Records,	a s s	Completed	Cerebral atrophy	7					24a. Wa	onsv	prior to co	opsy findings available ompletion of cause of
Ta L	Th ate	ø	Vascular dementia 25. Was case referred to medical	1			•	26. Place of	Death (Check only	(one)		2 □ No
on or VI	ding Phy n. After this funeral di	To B	examiner?  1 Yes 2 X No  27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date (Mo	Inpatient 2 [ e of Injury nth, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju Wo	ner: 4 □ Nursii	ng Home 5 ☐ Re 28d. Describe	sidence	Other (Specing occurred	<sub>ify)</sub> Assistant Living
DIVISION	pital or Attenors after deathers after deatheral Director; filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Plac	e of injury - At h ding, etc. <i>(Spe</i> c	iome, farm, str	eet, factory, office		28f. Location City or T	(Street an own, State	d Number or Rui	ral Route Number,
	ne Hospi 24 hour ne Funer	edical	29a. Certifier 1 A Certifying Ph (Check only one) 2 ☐ Medical Exam	niner: On the	ne best of my kn basis of examin nner stated.	owledge, deat ation and/or in	n occurred at the t vestigation, in my	me, date and popinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	To the within Comple	Me	29b. Signature and title of certifier				29c. Licens D 17				te signed <i>(Month</i>	
	8		30. Name and address of person who M. Vaid, MD	completed cat	use of death (Ite 1 Toled	m 23a) (Type, o Terr	Print) ace Suite	B-102	Hyattsv	ville	, MD 207	82
	Sta	te	31 Date filed (Mort 2007 Year)	32.	Registrar's Jon	and a				-		

DHMH 17 Rev 1/2001

			Plea	se Type or Prir						_	le.	
			for State Registrar	State of Ma	aryland		artment of F rtificate of	lealth and M	, ,	000		
P			Hegistrar     Decedent's Name (First, Middle)	e, Last)			tineate or		2. Date of Dea	eg. No.	3. Time of Death	_
P	Physici		Velma L. Mills					-	Tune	22 2°	207 12:33A M	
	/Medi Examir		4a. Facility Name (If not institution Doctor's Communication)				4b. City, Town, o Lanhai	or Location of Death		4c. County of		_
						ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1 9	Birthplace (State or Foreign	_
k	Funeral Director		5243-86-2004  Usual Residence of Decedent	1 □ M 2 💢 F	58	Yrs.	Months Days	Hours Min.	5/10/12	149 <sup>r)</sup> No	orfolk, VA	_
	yland now at		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits	_
	e Mar 3a-f sl itified	ctor	MD Prince	George's		New C	arrollto	n			Yes 2 No	
	h with th 23a or 24 st be no	al Dire	10e. Street and Number 5334 85th Ave	#B1			10f. Zip Code 2078	84	1	0g. Citizen of What USA	at Country?	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Armed Forces? ried 1 1 Yes 2 1 1 If Yes, Give			Was Decedent of Hif Yes, specify Cub	lispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No- Rican, etc.)	Black,	American Indian, White, etc.	
21215-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						Specify:	Black	
15-(	n 72 h "nati edica	lete	(Specify only higher	nt's Education est grade completed)	- 4	16a. Deced (Give life, I	dent's Usual Occup kind of work done DO NOT use retire	pation during most of workind)	ng	16b. Kind of Busin	ness/Industry	
212	d withi	E O	Elementary/Secondary (0-12)	College (1-4or 5 4yrs	+)		Process			Pri	vate	
Maryland 2	ld be filed lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Artis Mills	Last)	~			18. Mother's Name Martha	(First, Middle, I Drake			
ary	shou and M s mar	-	19a. Informant's Name/Relations	ship (Type. Print)		J.	-	and Number or Rura	l Route Numbe	r, City or Town, St.	ate, Zip Code)	_
≥,	and 2 lealth m 27 I		Frederick Hood,	Son	201 5	L	85th Ave			ton, MD		_
Baltimore,	Pages 1 ment of F ant: If Ite ury or ot	12	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (3		1 0	emetery, cirer Surrec		etery 7/2/		20c. Location - Ci	MD	
Balt	permit. Depart Import any inj once.		21. Sign Jure of Gameral Service	Linguisee		74	2. Name and Addre 74 Lando	ess of Facility J.B.	Jenki Landove	ns Funer	785 <sup>Home</sup>	
	- a.		23a. Part1. Enter the disease, o	r complications that caused tonly one cause on each lin	the death	. Do not ent	er the mode of dyir	ng, such as cardiac o	r respiratory arr	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		sis						Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as		,						
	_xammer	Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Res			ailure					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events		e II							
oʻ	e executed sian and urial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ence of):						
9289	cate bo	dical		d								_
.O. Box 6	ires that the death certificate be signed by the attending physicial be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnanc	у		23d. Date o Month		
<u> </u>	law requires that the as been signed by th 2 should be detache	/ Ph	Part II. Other significant conditi		ut not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?	_
rds	w requires been sign should be	ed by	Morbid Obe	esity					1 □ Y	es 212 No 3	☐ Probably 4 ☐ Unknown	
Records,	law re as bee 2 sho	Completed	Renal Fa	ilure					24a. Was a	n 24b. We	ere autopsy findings available or to completion of cause of	
H	The tage	Com							perfor	med? dea	ath? ☐Yes 2 No	
or Vital	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:			Oth	26. Place of Death	(Check only or	ne)		
ō		To	1 Yes 2 12 No 27. Manner of Death	28a. Date of Inju	1 Propatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (Spe							
ion	Attending r death. ector: After by the fune	atior	1 ☑Natural 5 ☐ Pendii 2 ☐ Accident invest	ng <i>(Month, Da</i> gation	/ Year)	Injury		rk? ]Yes 2 □No				
Division	al or Atte s after des l Directo d in by th	Certification:	3 Suicide 6 Could 4 Homicide detern		ry - At ho c. (Specify	me, farm, str	eet, factory, office	2	8f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical (	29a. Certifier 1 Certifyl (Check only one) 2 Medica	ng Physician: To the best Examiner: On the basis o and manner sta	examinat	wledge, deat ion and/or in	h occurred at the ti vestigation, in my	ime, date and place, a opinion, death occurre	and due to the ded at the time, o	ause(s) and manr date and place, an	ner as stated.  Indicate to the cause(s)	
	To the lawithin 2.	Me	29b. Signature and title of certific	Α	A .	an	29c. Licens			29d. Date signed (	(Month, Day, Year)	
	(6)		) Amv	el HStar	_ار		IM	DD 6061	1	0/2	5/2007	
	De		30. Name and address of person	who completed cause of d	eath (Item	23a) (Type,	Print)	8118 Go	od Luck	Rd. Lar	nham, MD 20706	;
Г	Sta Regist		31. Date filed (Month, Day, Year,	32. Registr	ar's Signal	ture	(					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 25, Elisabeth 10:44 PM Α. Moeller June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1651 Piccard Drive Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 341-30-5574 91 06, Oct. 1915 Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified of 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1651 Piccard Drive 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No 1 ☐ Yes 2 ☑ No ģ Specify 3 ☑ Widowed 4 ☐ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kar1 Tintelnot ို Antonie Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald J. Moeller / Son 1651 Piccard Drive, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Lincoln Crematory 6/29/2007 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. I ist only one cause on each line. Approximate Interval Between Onset and Death Immedia e Caus: (Final disease ir condition resulting in dealin) **Physician** Dehydration days /Medical Due to (or as a consequence of): **Examiner** Malnutrition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events resulting in death) Last <u>wee</u>ks Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Dementia years and Due to (or as a consequence of): physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by is certificate has been signed director, page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2**X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director; / 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31391 June 26, 2007 5 30. Name and address of person who con pleted cause of whath (Item 23a) (Type, Print) Suhair Abulfarag, M.D. 15215 Shady Grove Road #100, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year)

JUN 2

2007

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

DHMH 17 Rev 1/2001

32. Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene ron State RegistrayvFND#23a(a-c)perM¥6/27/07,Bwi,MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22, 2007 4:05 A. M McNelis Charles Anthony June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1X M 2 □ F 87 Director 202-10-6189 Sept.10, 1919 PA. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Directo MD. Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 407 Russell Avenue, # 812 20877 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2x Married 1942 Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: <u>≨</u> Specify: 3 Widowed 4 Divorced 1946 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Bernard McNelis Mary Carrol1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jean N. McN</u>elis/Wife 407 Russell Ave., # 812, Gaithersburg, Md. 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/28/2007 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home any ir 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition

a. Urinary tract infection

a. Acute Renal Failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Chostridium difficile colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-tran Acute renal failure Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2K No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 ☐ Yes 2X No 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide thin 24 hours at 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 me June 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve ...
31. Date filed (Month, Day, Ye M.D., 1355 Piccard Dr., # 100, Rockville, Maryland 20850 Génevieve Wroblewski, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For Stata Registrar	State of Ma		epartmen C <i>ertificat</i>			ind M	ental l		ene 🏻 🕻 j. No.	JU/	2250
	Physici	an	Decedent's Name (First, Middle, Last							2. Date of Month		Day	Year	3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give	Deskins M	ahoney	4b. City.	Town, or	Location of	f Death	JULY		4c. Count	2007 v of Death	1,39 AM
	Examin	IÇI	LINION HOSPITAL		COUNTY	ELKT			Dodin			CEC		
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	Director		219-20-6816 Usual Residence of Decedent	86	)	·				AÙG 1	Ζ,	1920	West	Virginia
	arylan show	<u>_</u>	10a. State 10b. County		10c. City, Town								11	0d. Inside City Limits 1 ☐ Yes 2 No
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	er dea Items	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Deced	lent of Hi	spanic Orig n, Mexican,	in? (Spe Puerto F	cify Yes or Rican, etc.	No-		ce - Americ	
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23e or 28e-1 show event. I're Medical Eracili or matter that the mailing at	Ď	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ∏Yes 2 ሺ No If Yes, Give Year or Dates:		1 ☐ Yes	2 <b>∑</b> No	Specify:				Specif	<sup>fy:</sup> Whi	te
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12	within lene. then	ошрі	Elementary/Secondary (0-12)	College (1-4or 5+)	)   _	ite. <i>Do not us</i> Iomemake		)				Tn H	ler Ow	n Home
Maryland 21215-0036	e filed al Hygi l other vent.	Be C	17. Father's Name (First, Middle, Last)			Tomemere		18. Mother	's Name	(First, Mic	idle, Ma	iden Sumar		ii iioliic
<u>   </u>	Menti Menti narked	To I	William Van Desk							ldair				
ā Z	od 2 st Ith and 27 Is n treun		19a. Informant's Name/Relationship (T) Teresa M. Gregg/(			Mailing Address Wood Ch								Code)
ore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural, or items 23a or 28e-f show any injury or other treumatic event. It a Medical Exaction for matter matter and once.	33	20a. Method of Disposition		20b. Place of D	isposition (Nan	ne of ther place		July			c. Location		wn, State
Baltimore,	ment tent: If		1 X Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)		Friends Ground	s Buria.	L	! 2	2007			alvert	, Mar	yland
Ba	permit Depar Impor any in once.		21. Signature of Funeral Service Licens	ee dish		Hicks I	Addres	s of Facility for f	uner	cals,	P. A	A.	larv1a	nd 21921
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the cause on each line	ne death. Do no								ur y ru	Approximate Interval Between
	Physician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	PNEUMO						0.811				Onset and Death
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	ם ב	iner	Sequentially list conditions, cause. Enter Underlying	Due to (prae a										
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Box	leath certific attending pl	Physician/M	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death	3 Ectopic pre							ite of deliver onth	ry Day Year
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	The law requires that the death certif te has been signed by the attending page 2 should be detached for use a	by	Part II. Other significant conditions con	ntributing to death but	not resulting in th	ne underlying ca	use give	n in Part I.						e cause of death?
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Vital	sicien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	In anihali				26. Place o		(Check on	ly one)			
ō	Physi r this o	1: To	1 Yes 2 No	lospital: 1 Inpatient			A Othe	r: 4 □ Nurs				e 6 Oth		)
0	Ntending F death. ctor: After y the funer	atior	1	28a. Date of Injury (Month, Day )	<i>'ear)</i> Inju		Work	? es 2 □ No		J =		inquity coodin		
DIVISION	or Attending Physicien: Ifter death. Director: After this certific in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, larm (Specify)	, street, lactory,	office		28	31. Locatio City or			er or Rural	Route Number,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Cartifying Phys	sician: To the best of	my knowledge, d	leath occurred a	at the time	e, date and	place, ar	nd due to t	he caus	e(s) and ma	anner as sta	ated.
	the Ho in 24 t the Fu pletely	Medicai	(Check only 2 Madical Examination)	nar: On the basis of ex and manner state	camination and/o	r investigation,	in my op	nion, death	occurre	d at the tim	e, date	and place,	and due to	the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifler	MD			License	number 6 34 8	01			Date signe		
		-	30. Name and address of person who co		th (Item 23a) (Tv			ا ۲ ر مر	06		0	501,	1 20	
			M.A. HAMADEH,	06 BOW S	TREET, E	LKTON	MI	219	21					
ţţ	Sta Registra	te ar	31. Date liled (Month, Day, Year) JUL 12 2007	32) Registrar's	Signature	red I								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar #31,32, TCHD, 06/21/07 pha Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 2007 17 ELIZABETH NICHOLS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ASTON nder 1 Year | If Under 24 Hrs. ن memoria la1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Months Hours 1 ☐ M 217 F Director 65 08-18-1941 Maryland 216-40-4225 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Md. Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 Street

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: 21601 Funeral 23 A Locust Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 28 Married 21215-0036 1 ☐ Yes 2X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laundry 11 Operator Laungi 18. Mother's Name (First, Middle, Maiden Surname) is marked other Maryland 17. Father's Name (First, Middle, Last) Be ၉ Helen Elizabeth Emory 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is South St., Easton, Maryland 21601

position (Name of 20c. Location - City or Town, State Victoria Dowling/Daughter 422 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Coppersville Cem. 06-25-07 Easton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 426 Dover St. Bennie Smith Funeral Home, Easton, Md. Nammie 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ndssive C /Medical Due to (or as a consequence of) Examiner neamic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Kidney Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mopths? Month Year 5 Other (specify) 1□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 2 1 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 1 2007

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,

7100			1 - For State Registrar	State of	Marylar		artmen rtificat			and M		giene Reg. No.	2007	22187
	Physic /Medi		Decedent's Name (First, Middle,  CHAR UFS		CRRI	15					2. Date of De Month	Day	Year	3. Time of Death
	Exami		4a. Facility Name (If not institution,	give street and numb	ner)		4b. City,	Town, or	Location o	of Death			ounty of Death	
			Carroll Hospita					tmin					rrol1	
	Funeral Director		5. Social Security Number 215-26-3123	3. Sex 7. 1 🔀 M 2 🗆 F	Age (In yrs. 75	last birthday) Yrs.	Months	Days Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth a <i>y</i> , <i>Year)</i>	Coui	
Since			Usual Residence of Decedent		/3		<u> </u>				02-19-	-1932	Mary	land
	h the Maryland r 28a-f show s notified at	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside City Limits
	e Ma 8a-f s	Director	Maryland Prince	George's	Co	llege ]	Park							1 X Yes 2 □ No
	with the	Ö	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cour	ntry?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show lical Examiner must be notified at	Funeral	5010 Delaware P	lace 12. Was Decede	ont Ever in III	6 10		0740		-1-0 (0	-16 - 16 - 16	U.S.		to die
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d 21	should be filed within and Mental Hygiene. s marked other than "umatic event, the Mec	ပ္ပ	12 17. Father's Name (First, Middle, La	ast)		Mast	er Ca:			r's Nama	(First, Middle,		actor	
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ary	2 shoul and M is mar	F	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			ouise S		e <b>r</b> own, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. once.		Edward T. Norri	s - Son									yland 2	
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Ĭ	Pag ment ant; I		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ale	t Line			i	06-2	9-2007	Breni	twood.	Maryland
3alt	permit. Pag Department Important: I any injury c		21. Signatur of Funeral Service Li	pensee A			2. Name and			_				more Ave.
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Box	ath ce	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	n 2 □ Fetal	Ideath 3□	Ectopic pre	gnancy				23d	. Date of delive	2
	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknowr		eath 5□	Other (spe	ecify)					Month	Day Year
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>	di isi	o Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	atient 2 □ I	ER/Outpatient		044			(Check only o		Other (Specify	
0 1	ding Ph n. After th funeral	Ë	27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date of I		28b. Time of Injury		ic. Injury a Work?			8d. Describe h			7
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Division	I or Attend after death Director: A I in by the f	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of	injury - At ho etc. (Specify	me, farm, stre	et, factory,	office		21	Bf. Location (S City or Tow	Street and N	lumber or Rurai	Route Number,
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	To the Hospital or within 24 hours after To the Funeral Dire	Medical	29a. Certifier (Check only one) Certifying I Medical Ex	Physician: To the be aminer: On the basis and manner	s or examinat	wledge, death ion and/or inv	occurred a estigation,	it the time in my opi	, date and nion, death	l place, a h occurre	nd due to the o d at the time,	cause(s) and date and pla	d manner as sta ace, and due to	ated. the cause(s)
	Vithi.	Ž	29b. Signature and title of certifier				29c.	License r	number		2		igned (Month, L	* * * * * * * * * * * * * * * * * * * *
	(5),		Man	~~	CE	>	I	30	26	3		0,	6-25-	-07
(	EX.		30. Name and address of person wh	o completed cause o	death (Item	23a) (Type, F	Print)	=, h	EST/	un:	rek,	MD:	21157	•
	Sta Registra		31. Date filed (Month, Day, Year) JUN 2 8 200	32Regit	strar's Signat	Sper	W				· · ·			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day /Medical Mary Dawson Popp June 27, 2007 8:45 p 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Assisted Living Center Solomons Calvert If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🖔 F Hours Min. Director 344-14-0706 84 04/18/1923 **Illinois** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Director 1 ☐ Yes 2X No <u> Maryland | Calvert</u> Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20688 Completed by Funeral 13325 Dowell Road United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify. 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph Dawson Charlotte Bradley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Mercure/Daughter 1505 Elk Point Drive, Reston, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 08/07/2007 Arlington, Virginia 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M0120622955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician pastrountes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Physician/Medical SB use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy o in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural Injury after death I Director; 2 Accident 1 Yes 2 □ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

Baltimore, Maryland 21215-0036

State Registrar

person who completed cause of death (Item 23a) (Type, Print) 30. Name and address D.O. 40 Jennifer Schmidt,

40900 Merchants Lane, Suite 205, Leonardtown, MD

HUU55751

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

JUL 0 2 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Of Ma State Registrar		artment of Healt rtificate of Dea		tal Hygie Reg.	,	07	22439
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last)  Deloris Irene PE	IRCE			Date of Death Month	Day	Year	3. Time of Death
	Examir	-0.00	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locati			4c. County		
		4	Washington County Hospital		Hagerstown		1.00	Washi	ingtor	
	Funeral Director		217-28-1230 1□ M 2対 F	73 Yrs.	If Under 1 Year If Un Months Days Hou	rs Min. (	Date of Birth Month, Day, Youth		9. Birthpli Count Mary	
	faryland show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Washington	10c. City, Town or Lo	cation				10	od. Inside City Limits 1 ☐ Yes 2 XXNo
	the N 28a-	rect	10e. Street and Number	ralipiay	10f. Zip Code		10g	. Citizen of V	Vhat Count	ry?
	3a or	ΙD	18038 Lappans Road		21733	3		U.S.	Α.	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent F Armed Forces?  1 □ Yes 2 ☑ N  If Yes, Give Year or Dates:	lo l	Was Decedent of Hispanic If Yes, specify Cuban, Mex I ☐ Yes 2X No Spec		Yes or No- n, etc.)	Blac	e - America k, White, e whi	tc.
21215-0036	ithin 72 ho ne. nan "natul	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occupation kind of work done during i DO NOT use retired)	most of working	16	b. Kind of Bu		•
72	iled w Hygier ther th		11 0	Tac	tory worker	lother's Name (Fir	st Middle Ma		on ma	anur.
and	d be f ental F ced of	o Be	John C. Armstrong		10.19		cene G.		,c)	
Z	shoull nd Me mark	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Nu	ımber or Rural Ro	ute Number, C	ity or Town,	State, Zip	Code)
ž	and 2 alth a 27 is		Richard A. Peirce - husband	1803	8 Lappans Ro	oad, Fair	play,	Maryla	and 2	21733
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of matory or other place) wn Memorial	July 5,		c. Location -	-	vn, State Maryland
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee	22	2. Name and Address of Fa 15 East Wils	acility Minn	ich Fur	neral	Home	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)  Due to (or as	spiratory arrest	,		Approximate Interval Between Onset and Death			
68760,	tificate be executed was in a supposed as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events  c.	a consequence of):	BILATI					
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 □ Yes 2 □ W6 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Dat	e of deliver	y Day Year
ທົ	quires that in signed by aid be detail	by	Part II. Other significant conditions contributing to death but	it not resulting in the u	nderlying cause given in Po	art I.	23e. Did tobac	co use contr	ribute to the	e cause of death? ably 4 □Unknown
or Vital Record	The la ate has page 2	Completed					24a. Was an autopsy performe 1□ Yes 2 •	d?	Were autoportor to condeath?	sy findings available opletion of cause of 2  No
<u></u>	Physician: this certificated director, is	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	Othor	Place of Death (Ch				
Ö	g Physer this eral di	7: 70	27. Manner of Death 28a. Date of Injur	y 28b, Time of	R S BOA 4L	Nursing Home 28d.	Describe how			)
ion	Attending Ir death. ector: After by the funer	atio	1 ☑ Matural 5 □ Pending (Month, Day 2 □ Accident investigation	Year) Injury	M 1 Yes 2	2 □ No				
Division	al or Attends after death I Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined building, etc	ry - At home, farm, str . <i>(Specify)</i>	eet, factory, office	28f. I	ocation (Stree City or Town, S	et and Numb State)	er or Rural	Route Number,
	To the Hospital or Attending Phwithin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	due to the caus t the time, date	se(s) and ma e and place,	anner as sta and due to	ated. the cause(s)			
	To the within 2 То the соттрые	Me	29b. Signature and title of certifier		29c. License numb			. Date signe		
			Bur Mohen, v	(D)	P0001	1040	0	6-30	- ZO	07
غ	4-4			eath (Item 23a) (Type,	Print) HAVERST	our, u	D 217	40		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registra	rr's Signature	HAVERST					

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kenneth Allen Price State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle.Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 6, 2007 0831 hrs Medical Examiner Price Kenneth Allen 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington 436 George Street Hagerstown If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Comennsylvania Months Days Hours Director March 14,1964 43 XXM 2 F 169-56-0273 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County X Yes 2 No Hagerstown Washington Maryland with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 436 George Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married Yes 2 X No If Yes, Give Year Yes 2 X No specify: Widowed 4 White Divorced <u>\$</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) other than Baltimore, MD 21215-0036 Hardwood Floor Instal Carpenter and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Pages I and 2 should be filed nent of Health and Mental Hyg If item 27 is marked Be Alberta Means Lvda Elwood Elmer Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7225 19a. Informant's Name/Relationship (Type, Print) 3518 Coseytown Rd. Greencastle, Pennsylvania Jerry L. Price - Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State crematory or other place) Smithsburg Crematory | July 9,2007 Smithsburg, Maryland Donation 5 Other Spec 21. Inatury of Funeral Sa OSBOPANEADERSHER HOME, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and Death failure. List only one cause on each line Medical Ischemic bowel disease with complications Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical signed by the attending physician a be detached for use as the burial -XUNPENDED AMENDED #23a.27.perME.g871.9/26/07 TT law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month I ive birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 1 Yes Νo this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other<sub>4</sub> Hospital: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: X Natural Yes 2 No Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Director: Medical

State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

32. Registrar's Signature

Could not be

30. Name and address of person who completed cause of death (Item 23a)

(Specify)

and manner stated

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Reody

31. Date filed (Month, Pay, Year)

Theodore M. King, Jr., MD.

one)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

OCME

July 7, 2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended # 1- State 17, #19a, FH, TCHD, 06/21/07, pha Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Luther William Peyton 6 /Medical 2007 7:55a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner William Hill Manor Easton Talbot 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 1 M 2 □ F 266-72-1981 Director Yrs 11-23-1914 Georgia Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 77 le marked other than "naturel", or iteme 23a or 28a-f show traumatic event, the Madical Examinar must be multified at Md Talbot Easton Director 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Dutchmans Lane 21601 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. In marked other than "naturel", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Date Navy WWII 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Superintant Mail U.S. Post Office 12 years Superintendent of
18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last)

John Humpreys Peyton Be Maude Frohock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 ie m any njury or other traum onc. Barbra J. McNally (daughter) hter) 27050 St Michaels Rd. P.O. Box 2434

20b. Place of Disposition (Name of Page)

20c. Location - City or Town, State Barbara 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 6-17-2007 Dover De. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxi a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 200 respurator /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ned by the attending physician and detached for use as the burial-transit the death certificate be executed Due to (or as a donsequence of) Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Huknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt 1 be c Completed by been sig 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 210 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one, Hospital: Other: 1 ☐ Yes 2 ₺ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral of 27. Mann of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospitel or Attendir within 24 hours after death.
To the Funerel Director: At completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

12+VA

William H. MD 501 Dutchmans Lane, Easton, Md. 21601 Wood, Jr

29c. License number

29d. Date signed (Month., Day, Year)

State Registra

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07-04763	
Jeffrev William	Poole

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death		, 0	g. No.	A CHAPA
Physicia	n/	1. Decedent's Name (First, Middle,Last)		2. Date of Deat Month	×	3. Time of Death
fledical Examir	ıer	outlety within roote	own, or Location of D	June 22, 2	007 4c. County of Death	1625 hrs
		3185 Rolling Road Edgew		Scalin	Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under			Farais	thplace (State or
Director		579-94-2594 1XM 2 F 36 Yrs. Months	Days Hours	Min: 2/5/19	71 Co	untry) Maryland
E STATE OF THE STA	. 1984 - 1. J. Ta	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ž .	٦	MD Anne Arundel Edgewater				1 Yes 2 X No
Maryland 28a-f show d at once.	ect	10e. Street and Number 10f. Zip C	Code	, . 10	g. Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once	اَةٍ	3185 Rolling Road	21037	9 7 5	USA	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examinor must be notified at once	Funeral Director	1 V Never Married 2 Married Armed Forces? If Yes, specify	nt of Hispanic Origin' ⁄ Cuban, Mexican, P	? ( Specify Yes or No- uerto Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
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5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examinators	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual O  during most of work	Occupation (Give kin		16b. Kind of Business/	Industry
36 in 72 h lian "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ing ine. DO NO1 us	, e retired		
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21215-0036 Build be filed within 7 Mental Hygiene. marked other than	Be	William Poole Jr.		n Marie As	,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	2	The state of the s			ber, City or Town, State	e, Zip Code)
Baltimore, MD oemit. Pages I and 2 sho Department of Health and Important: If item 27 is njury or other traumati	-	Ellen Marie Poole Mother 1654 Forest  20a. Method of Disposition 20b. Place of Disposition (Name		napolis, M	D 21403 20c. Location - City or	Town State
nore ges 1 : nt of H t: If it		1 Burial 2 XX Cremation 3 Removal from State crematory or other place)			<u> </u>	
ultim nit. Pa artmer oortani	-	4 Donation 5 Other Specify: Metro Crematory 21. Signature of Fugeral Service Licegise 22. Name and A		6/25/2007	Baltimore, uneral Home	
Dep Dent	ļ	Day M 12 Ridge	gely Ave.	Annapoli	s. MD 21401	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	dying, such as card	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner	İ	Immediate Cause (Final disease or condition resulting in death)  a. Contact Shotgun Wound of Head  Due to (or as a consequence of):		0		Death
		Sequentially list conditions,  b.				
	je.	If any, leading to immediate  Bue to (or as a consequence of):  Bue to (or as a consequence of):	9			
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vecuter and rans		d.				
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5876 ertifica ling ph	= 1	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death	3 Ectopic p	regnancy	23d. Date of deliver Month	Day Year
Box 687 ne death certifit the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	fy)		1	
that the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part	I. 23e. Did to	bacco use contribute to	the cause of death?
ords, P.O.	d b			1 Yes	2 V No 3 Pro	pably 4 Unknown
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Recc The lav	E I		• • • • • • • • • • • • • • • • • • • •	perfor		es 2 No
Division of Vital Records, ra der death.  To Attending Physician: The law requiring after death.  A Director: After this certificate has been so led in by the funeral director, page 2 should led.	Be C	examiner?	6.Place of Death (CI			
f Vir	ို	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DO	OA Other N		Residence 6  Othe	r: Scene
ion of vending Phyeath.  tending Phyeath.  tor: After the funeral	흲	1 Natural 5 Pending FOUND: FOUND:	1 Yes 2 ✔ N	Subject shot		
Visic or Atte fler des directo	ertification:	2 Accident Investigation Jun 22, 2007 1619 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, or	office building, etc.			ral Route Number, City
Divi	팅	4 Homicide determined (Specify) residence		or Town, S 3185 Rolling F	tate) Road, Edgewater, MD	)
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	edical	29a. Certifier (Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my one)				
To To Com	Med	and manner stated	License number		29d. Date signed (Mo	
		Pote Com - Polosus	O.C.M.E.		June 23, 2007	
John	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
offs.			nn Street, Balti	more, MD 21201	<u> </u>	
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature				
DHMH 17 Rev 1/20	01	OCMF ORIGINAL				

State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar		, , , , , , ,	C	ertific	ate of	Death	1	ornar rry	Reg. N	lo.		22101
Phys	ioio	5	1. Decedent's Name (First, Middle, La	1							2. Date of De		ay	Year	3. Time of Death
	dic		Catherine Barge								June	2		2007	07:22 A <sup>M</sup>
Exa	mine	er	4a. Facility Name (If not institution, gi		4b. C	ity, Town, o	r Location	of Death		4	c. County	of Death			
			Anne Arundel Med 5. Social Security Number 6.		r e (In yrs. la	oot hiethe		napol:		r 2/1 ∐re	8. Date of Bi		Anne		
Fune Direct				1 M 2 XF 8.5		Yrs	Mont	hs Days	Hours	Min.	(Month, Day 11/23/	ay, Yea	21	Geor	elace (State or Foreign etry) gia
land ow It		ŀ	10a. State 10b. County		10c. City	, Town o	r Location							1	0d. Inside City Limits
ine, INIAI yialla ZIZIS-DUSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Them 27 is marked other than "natural", or Items 23a or 28a-f show offer traumatic event, the Medical Examiner must be notified at		Director	Maryland Anne Ar	undel	Arn	old									1 ☐ Yes 2 🛣 No
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ter de Item Iner r		Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🛣	Ever in U.S	5.	If Yes,	specify Cuba	an, Mexica	in, Puerto	cify Yes or No Rican, etc.)	0-		k, White,	
urs af al", or ixam		ል	3 ☐ Widowed 4 M Divorced	If Yes, Give Year or Dates:	10		1 ☐ Ye	s 2 <b>X)</b> No	Specify.	:			Specify.	· Wh	ite
72 hou natura	11	Completed	15. Decedent's E (Specify only highest gi	Education		16a. De	ecedent's l	Isual Occup	ation	-4 -4d-i-i-		16b.	Kind of Bu		
Ithin 7 Ithin		nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)			work done of use retired		Si Di WOIKII		ľ			
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hould d Me mark matic		၉	19a. Informant's Name/Relationship	(Time Print)		10b M	lailing Add	ann (Straat			il Route Numb	han City	. a. Taur	Ctata Zia	· Code
rvid d 2 s lth an 17 ls i traui			·	, , ,			_								Code)
tem 2		1	Kimberly Brand/D 20a. Method of Disposition		20b. Pl	ace of Di	isposition (	Name of	1		ld, Mar Pate		Ind Z1 Location -		own, State
parmit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau			1 ☐ Burial 2 X Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State			<sub>crematory</sub> remat	or other plac Or V		06/24	4/2007	Ed	gewat	er.	Maryland
mit. I partm portal	ej j	1	21. Signature of Funeral	The second secon	_	_	22. Name	and Addre	ss of Facil	ityGeor	rge P.	Kal	as Fu	inera	1 Home
	ouce.	1	Moto	1.6/	22		<b>2</b> 973	Solomo	ons I	sland	d Rd., E	Edge	water	, MD	21037
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lir	the dentine.	. Do not	enter the r	node of dyir	g, such as	s cardiac o	r respiratory a	arrest,			Approximate Interval Between
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/Medic Examin	-		resulting in death)	Due to (or as	a consequ	ence of):									
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leath cert attendin			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □Live birth			2∏Estoni	c pregnancy	,				23d. Date	e of delivery	
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sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit		2	Part II. Other significant conditions	contributing to death bi	ut not resu	iting in th	e underlyir	ig cause giv	en in Part	1.			_/	obute to th 3 ☐ Prob	ne cause of death? nably 4 □Unknown
w rec		lete									24a. Was	an	24b. V	Vere auto	psy findings available
The late te has age 2		Completed									auto perfe 1∐ Yes	opsy ormed7 2 ☑ 1	Z B	rior to co leath? Yes	mpletion of cause of 2 ☐ No
ian: irtifica tor, p		Be	25. Was case referred to medical examiner?	ki /					26. Place	e of Death	(Check only		10		20110
hysic his ce I direc		0	1 ☐ Yes 2 ☐ Mo	Hospital: Inpatie	ent 2 🗆 E	ER/Outpa	itient 3	DOA Oth	er: 4 🗆 N	ursing Hor	ne 5□Res	idence	6 □Othe	er (Specif	y)
ing P			27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry y Year)	28b. Tim Inju	ry	28c. Injur Worl		- 1	28d. Describe	how in	jury occurre	ed	
tend leath. tor: /		cati	2 Accident investigation 3 Suicide 6 Could not be		un. At hor		M		Yes 2□						
The state of the s								tory, office		2	City or To	wn, Sta	ana Numbe ate)	er or Hura	l Route Number,
spital spurs neral y filled			29a. Certifier 1 ☐ €ertifying P	hysician: To the best of	of my knov	vledge, d	eath occur	red at the tir	ne, date a	nd place, a	and due to the	cause	(s) and ma	nner as s	tated.
the Hc in 24 I he Fu pletel	29a. Certifier  (Check only one)  29a. C										and due to	o the cause(s)			
To t To t		Ž	29b. Signature and title of certifier	1	1			29c Licens	e number	, _		29d. E	Date signed	(Month,	Day, Year)
~ 0	40			milh M	N			11/3	840	10		Vi	INL	23,	JU17
100	Pr.		30. Name and address of person who	completed cause of de	eath (Item	23a) (Ty	pe, Print)	11/10	- 4,	BV	6. A	$U\mathcal{N}$	470	4.	Mo
Rea	Stat		31. Date filed (Month, Day, Year)		ar's Signat	ure .	-1	J			/		/		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Physician Month Norah May Payne 2:25 A.M 24, June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 10707 Kenilworth Avenue Montgomery Garrett Park 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 1,1910 9. Birthplace (State or Foreign Country)
England 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🛣 F 97 578-24-5491 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a, State 10b. County 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Maryland Montgomery Garrett Park Director 1 XIYes 2 □ No 10e, Street and Number 10g. Citizen of What Country? 10707 Kenilworth Avenue 20896 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 Widowed 4 □ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Russell Kate James ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4710 Waverly Avenue, Garrett Park, MD 20896 19a. Informant's Name/Relationship (Type. Print) Pamela Nancy Morgan/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Geo. Wash. University June 24 Medical Center 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Washington, D.C. Bignature of Juneral Service License 22. Name and Address of Facility Columbia Mortuary Services, Inc. 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MD AAL or as a consequ disease or condition resulting in death) /Medical ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician are the burial-t Due to (or as a consequence of) Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a ld be detached for 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate ha 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 2 1 Yes 2 No 1 🔲 Inpatient After this 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred s after dea. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours at

> State Registrar

29b. Signature and title of certifie

100N

use of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

1. 94	Physic		1 - State Registrar  1. Decedent's Name (First, Middle, Las Richard A	st)			ent of Health a ate of Death	2		leg. No.	2007	3. Time of Death	
	/Medi Exami		4a. Facility Name (If not institution, give	e street and number)		4b. C	ity, Town, or Location of	of Death	<u>,</u>		County of Death Frederi		
Pa.	Funeral Director		215-34-6028	ex 7. Age	80 Yrs	Mont	der 1 Year If Under ns Days Hours	Min.	Date of Birth (Month, Day	, Year)	Coun	lace <i>(Stat</i> e or Forei try) <b>yland</b>	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	or	Usual Residence of Decedent  10a, State  10b, County		10c. City, Town or	Location					10d. Inside		
	r 28a-	Director	Maryland Fred  10e. Street and Number	erick		10f.	Frederic Zip Code	K	1	l0g. Citize	en of What Coun		
	th with	aD	9712 Woodsbor	o Rd.			21701			l	J.S.A.		
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 Yes 2 N	Ever in U.S. 1	3. Was De	cedent of Hispanic Ori pecify Cuban, Mexicar	gin? (Specit	y Yes or No-		4. Race - Americ Black, White,		
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖰 N If Yes, Give Year or Dates:	lo		2 № No Specify:	•	, ,	s	ite		
5-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De	cedent's L	sual Occupation work done during mos use retired)	t of working		16b. Kind	d of Business/Inc	dustry	
2121	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ctrician				electr	ical	
DQ 2	e filed al Hyg other vent, 1	Be	17. Father's Name (First, Middle, Last)					er's Name (F	irst, Middle,	Maiden Surname)			
Maryland	Duid b Menta arked atic e	To	Charles Willi	am Peddico	rd, Sr.			France	s Selv	vay			
Mar	12 sho h and 7 is m raum	8 -	19a. Informant's Name/Relationship (	/			ess (Street and Number						
e,	1 and Healt em 2	3	Margaret Peddicord/ wife 9712 Woodsboro Rd. Frederick, MD 21  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City of Commetters of Commetters and Commetters of Commetters and Commetters of Commetters and Commetters of Commetters and Commetters of Commette										
Baltimore,	Pages ment of ant: If it ury or c		1 □ <b>X</b> Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Specif</i> y		Chapel (		1	7/10/2	1		.ibertyt		
Ball	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.	Į,	21. Signature of Funeral Service Licental American	Xarzle	~	1180	and Address of Facilit 2 <b>Liberty</b> I	Rd.	Libert	ytow	al Home n, MD 2		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin a. SQU	AMOUS		node of dying, such as		- 20	est,		Approximate Interval Between Onset and Death	
	Examiner			Due to (or as a	consequence of):							,	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):								
	cecute and I-trans	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):	lience of							
68760,	ate be executed only sician and the burial-transit	g		•d									
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death	3 □Ectopie 5 □ Other	pregnancy (specify)			23	d. Date of delive Month	ry Day Year	
rds, P.	w requires that the de i been signed by the s should be detached i	þ	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the	e underlyin	g cause given in Part I.			bacco use		e cause of death? ably 4 ∐Unkno	
or Vital Records,		Completed							24a. Was a autops perform	med?	24b. Were autop prior to con death? 1 ☐ Yes	osy findings availal npletion of cause o	
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Manadali				of Death (C	heck only on				
or	Phys this aldii	2	1 Yes 2 No 27. Manner of Death		t 2 ER/Outpat						Other (Specify	)	
Division	ding I. After fune	ertification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day			28c. Injury at Work? 1 ☐ Yes 2 ☐ I	Ì	. Describe ho	ow injury o	occurred		
Divi	al or Attences after death	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injurbuilding, etc.	ry - At home, farm, . (Specify)	street, fact	ory, office	28f.	Location (St City or Town	reet and I n, State)	Number or Rura	Route Number,	

Be Medical Certification: To

To the Hospital or Attending Physiciar within 24 hours after death.

To the Funeral Director; After this certif completely filled in by the funeral directon

29a. Certifier (Check only one)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of cordifier

29c. License number D32171 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALKERSVILLE, MD

State Registrar 31. Date filed (Month, Day, Year)

RICUSED

POBON

DHMH 17 Rev 1/2001

07-05047 Kenneth Richard		Otate of Marylana / Dope	artment c	of Health and			ble.				
		1- For State Registrar  1. Decedent's Name (First, Middle, Last)	rtificate c	f Death		Reg.	No.	, , , , , , , ,			
Physicia Medical Examin		Kenneth Richard Potter IV				2. Date of Death Month D: July 2, 2007	ay Year	3. Time of Death 0815 hrs			
The same of the sa		4a. Facility Name (if not institution, give street and number) 3629 Fontron Drive		4b. City, Town, or Edgewater	Location of Death	Odiy 2, 2007	4c. County of Deat				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Birth (	MM/DD/YYYY) 9. Bi				
Director		215-23-0468	Yr	Months Days	Hours Min.	08/07/1	986 Forei	ountry)Maryland			
* any	Ì	10a. State 10b. County 10c. City	, Town or Loca	ition				10d. Inside City Limits			
Maryland 28a-f show d at once	호	Maryland Anne Arundel Edg	gewater					1 Yes 2 X No			
or 282	Director	3629 Fontron Drive		10f. Zip Code 21037			Citizen of What Cou	•			
		11. Marital Status 12. Was Decedent Ever in U	l.S. 13. W	as Decedent of His	panic Origin? ( Sp			rican Indian, Black,			
death or iten	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	lf '	Yes, specify Cuban	, Mexican, Puerto I	Rican, etc.)	White, etc.				
rs after ural",	à	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	1 1	Yes 2 X No		Tac	Specify: Whi				
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		nt's Usual Occupat nost of working life.			6b. Kind of Business	industry			
036 vithin ene.	du	12	Cashi	er			Grocery S	tore			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)  Kenneth Richard Potter III			18.Mother's Name						
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	To Be	Kenneth Richard Potter III Diane Carol Freburger  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									
MD and 2 show alth and m 27 is a aumatic		Kenneth Richard Potter III/Fath	er 3629	Fontron	Drive, Ed	dgewater,	, Maryland	1 21037			
Baltimore, ML pemit. Pages I and 2 s Department of Health at Important: If item 27		1 Burial 2 X Cremation 3 Removal from State	crematory or o		<i>*</i>	ŀ	0c. Location - City o	Town, State			
		4 Donation 5 Other Specify: Ka	las Cre					Maryland			
Balti permit. Departm Imports injury o		21. Signatur st metal artice Limisee				_	alas Funer Igewater,				
Physician	1	23a. Part I. Enter the disease, or complications that caused the death					_ ,	Approximate Interval			
/Medical	ı	failure. List only one cause on each line.  Immediate Cause (Final disease a. Heroin intoxicat	ion and d	ocaine use	en ec			Between Onset and Death			
		or condition resulting in death)  Due to (or as a consequence of									
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of									
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executed an and al-transit	<u>a</u>	d						<u> </u>			
ਹ ਛਾਛਾ .	ğ	X UNPENDED AMENDED, 27, 28a-f,	perME, g	869,7/13/0	7 TT						
, P.O. Box 68760, res that the death certificate be excising by the attending physician be detached for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the	nancy	etal death 3	Ectopic pregnar	ncv	23d. Date of deliver	y Day Year			
ath cer attendi	sicia	past 12 months?  4 Pregnant at time of de	noth	ther (Specify)				,			
D. B. the de by the	전	Part II. Other significant conditions contributing to death but not r	esulting in the	underlying cause o	iven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?			
P.O.	d b					1 Yes		bably 4 🗸 Unknown			
ords, w requires been should	Completed					24a. Was an autopsy		utopsy findings available completion of cause of			
RecC The lay	E					performe	ed? death?				
tal Recc cian: The lar certificate ha	e Be	25. Was case referred to medical examiner?	-		of Death (Check o	nly one)					
Division of Vital Records, tal or Attending Physician: The law require rs after death.  In Director: After this certificate has been sided in by the funeral director, page 2 should be a feel in by the funeral director, page 2 should be a second or the funeral director.	의	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2  7. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of				sidence 6 🗸 Othe	r: Scene			
on of anding Ph.  ri. After the funeral	<u></u>	Natural 5 Pending (Month, Day, Year)  FNd 7/2/2007			'05 2 37 No	28d. Describe how unk	rinjury occurred				
ViSiOr or Attend frer death Director: in by the	iig ii	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At h	FNd 8:1 ome, farm, stre	O am		28f. Location (Stre		ural Route Number, City			
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	4 Homicide determined (Specify) found	in resid	ence		or Town, State 3629 Font:	ron Dr. Edge	water. MD			
		29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a									
To the within.  To the comple	Medical	and manner stated.  29b. Signature and title of certifier		29c. License			9d. Date signed (Mo				
		Mling de assell MID		O.C.N			luly 3, 2007	, , , , , , , , , , , , , , , , , , , ,			
	ł	30. Name and address of person who completed cause of death (Item									
		Melissa Brassell, MD Assistant Medical Examin		Penn Street, B	altimore, MD 2	21201					
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	n e								

DHMH 17 Rev 1/2001 OCME 2006

	, P.O. Box 68760,
Tropa, Dock	ion or Vital Records
Ċ	Divis

			Please Type or Prin						ible.
			1 - State Of IVIA		partment of Fertificate of			giene Reg. No.	705 9510
8	6	ă,	Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
- N.	Physic /Medi		Dorothy Marie	Rutherfo	ord		Month 0 7	OH.	2007 2014 M
	Exami	ner	4a. Facility Name (If not institution, give street and number)			or Location of Death		4c. Count	ty of Death
	Funeral	, 278., 27	St. Mary's Hospital  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday		rdtown If Under 24 Hrs.	8. Date of Bir		Mary's  9. Birthplace (State or Foreign
	Director		215-62-3951 1□M 2⅓F	55 Yrs.	Months Days	Hours Min.	June 4,	1952	District of Columb
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	Location				10d. Inside City Limits
	Maryl -f sho fied a	tor	Maryland St. Mary's	Hollyw					1 ☐ Yes 2 XX No
	or 28a e noti	Jirec	10e. Street and Number	110117	10f. Zip Code			10g. Citizen of	What Country?
	ath wi	ral	44629 Clarkes Landing Road		20636				JSA
	ter de items	Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ Ⅵ.		<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla	ace - American Indian, ack, White, etc.
036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 📉 Married 1 ☐ Yes 2 📉 No. If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	<u> </u>	1 ☐ Yes 2 🏋 No	Specify:		Specia	<sup>ify:</sup> White
2-0	72 hc 'natul dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occup ve kind of work done	oation during most of worki	ina I	16b. Kind of E	Business/Industry
121	within ene. than he Me	Idmo	Elementary/Secondary (0-12) College (1-4or 5+	-}	ve kind of work done DO NOT use retired tender	d)	9	Resta	urant
d 2	be filed within 72 hours after death with the Marylar ital Hygiene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Co	17. Father's Name (First, Middle, Last)	Dar	cender	18. Mother's Name	(First, Middle,	<u> </u>	
/lar	12 should be f and Mental l Is marked of raumatic eve	To B	Adrian Joseph Glass			Esther	Noreen	McNult	у
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type. Print)		iling Address (Street				
	permit. Pages 1 and 2 should t Department of Health and Ment Important: If Item 27 is marked any injury or other traumatic e once.		Paul David Rutherford / Husband  20a. Method of Disposition		Clarkes La		Hollywood		
Baltimore,	Pages Tent of Int: If its		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	l .	position (Name of ematory or other place can Cremator				- City or Town, State
alti	permit. P Departm Importar any injur		21. Signature of Funeral Service Licensee						ia, Virginia Funeral Home, P.A.
8	a a E is a		Michael Keven Hardiner		P.O. Box 270				
38			23a. Part1. Enter the dise de, or complications that caused shock, or heart failure. List only one cause on each line	he death. Do not en	nter the mode of dyir	ng, such as cardiac o	r respiratory ar	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a.		7 disea	N Carol	, (~)	ILC CO	Onset and Death
	Examiner		AL . S.	consequence of):	11.	,			200.1
D)		ner	Sequentially list conditions, if any, Isaamy to immediate cause. Enter Underlying Cause (Disease or injury	consequence of).	ال ما ل				yews
	be executed sician and burial-transit	Examine	regulting in death) Last		*	<u> </u>			yews
760,	s be ey sician buria			consequence of);					
687	death certificate b e attending physic d for use as the b	Physician/Medical	d						
Вох	ath cer ttendir or use	an/In	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome printing in the past 12 months?		□Ectopic pregnancy	,			ate of delivery
	0 0 0	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)		-	Mo	onth Day Year
۳.	requires that the de een signed by the a nould be detached		Part II. Other significant conditions contributing to death but	not resulting in the I	underlying cause give	en in Part I.	23e. Did to	obacco use con	stribute to the cause of death?
rds	w requires that been signed should be det	q pa	Break Concer Lyperlessio	~ Prev	munia		1 🗆 Y	′es 2□No	3 ☐ Probably 4 ☐ Unknown
၁	law asb 2sl	Completed by		, ,			24a. Was a		Were autopsy findings available
a B	t The cate his page	Com.					autop perfoi 1∐ Yes	rmed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Zi Zi	Attending Physician: Th refath. retath. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		ont 3ELDOA Othe	26. Place of Death	(Check only or	ne)	
0	g Phys er this eral dir	1: To	27. Manner of Death 28a. Date of Injury	28b. Time o	III 3 DOA	4 LI Nursing Hor		lence 6 Oth	
ion	ath. or: After ne funer	atio	Natural 5 ☐ Pending (Month, Day 1)  Accident investigation	Year) Injury		k? Yes 2 □ No			
i	pital or Attending Physician: The uurs after death. teral Director: After this certificate hi filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc.	y - At home, farm, st (Specify)	treet, factory, office	2	8f. Location (S City or Tow	itreet and Numb	ber or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier Certifying Physician: To the best of	my knowledge dog	th occurred at the tin	no data and also			
	To the Hos within 24 ho To the Fun completely	edical	(Check only one) 2 Medical Examiner: On the basis of e and manner state	xamination and/or ir	nvestigation, in my o	pinion, death occurre	ed at the time,	date and place,	anner as stated. and due to the cause(s)
ا ہ	To the within 2 To the complete		29b. Signature and title of certifier		29c. License	e number	2	29d. Date signe	ed (Month, Day, Year)
	/		In a slow		HG	,3519		7/4/7	)
	M		30. Name and address of deast of the second	th (Item 23a) (Type,	Print)	1 0	1.	, ,,,,,	N 2 - CO
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar	s Signature	Sunt looky	1,017	Conuch	ton, 1	1D 50620
34	Registra	ar	JUL 0 6 2007	A A	343				
DHM	IH 17 Rev 1/20	01							

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 06 Day 23 2007 **Physician** 1:41A M Flossie Lillian Reed /Medical 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince George's Date of Birth (Month, Day, Year) 10/24/1908 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 214-30-2107 1 □ M 2 🖸 F 98 Yrs Winsboro, SC Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygene.
To is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Prince George's Brentwood Director 10f. Zip Code 20722 10e. Street and Number 10g. Citizen of What Country? 4031 Webster St Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>ک</u> 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Wallace Ford Adeline Kitchen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Wallace Reid/ Greatgrandson 4031 Webster St, Brentwood, MD 20722 other Department of Healt Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1√ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 6/30/2007 Brentwood, MD 21. Signature of Funeral Service Ocensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd, Brentwood, MD 20722 Ketrerd 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fa ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or conditior resulting in death) ARRYTHMIA ARDIAC /Medical Due to (or as a consequence of): **Examiner** LEUZIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner that the death certificate be executed ASPIRATION PNEUMONI and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No al or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 (Inpatient Other: 1 Yes 2 No 2 2 ER/Outpatient 3 DOA  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$  Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident Injury 5 | Pending 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-17874 6-25-07 2 By 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COTTAGE CITY, MD 20722 .S. M. NAYAR 3717 State Registrar

1 - For State Registrar

Physician

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

Marion Dorthea Reeder

4a. Facility Name (If not institution, give street and number)

Bandler.	
Records,	
Vital	
ō	
Division	

			Doctor's H	lospital			anham		Prince	e George's
	Funeral		5. Social Security Number	6. Sex 7. As	ge (In yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs. 8. Da Hours Min. (M	te of Birth onth, Day, Ye	9. Birt	hplace (State or Foreign untry)
in.	Director		214-32-7864	I I W ZLA	73 Yrs.		Feb	. 20,	1934	Wash., DC
	pr ,		Usual Residence of Decedent		10c. City, Town or L	onation	<u> </u>		· · ·	10d. Inside City Limits
	arylar shov d at	_	10a. State 10b. County		Toc. City, Town of E	ocation				1 ☑ Yes 2 ☐ No
	e Ma 3a-f s	5	Maryland   Princ	e George's			Landover			4.3,
	end	Oire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	th wi	] a	1317 Capital	. View Terrac			20785		United	States
	dea ems	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	Was Decedent of Hi	spanic Origin? (Specify Y n, Mexican, Puerto Rican	es or No- etc.)	14. Race - Ame Black, White	
စ္	after or ite mine		1 Never Married 2 Mar	rried 1 Tyes 2 Ty		1∐Yes 257No	Specify:			rican
93	ours ral", Exa	d b	3 Widowed 4 Divorced	Year or Dates:		-X.			Ame	erican
5-0	72 h natu dical	etec	15. Deceder	nt's Education est grade completed)	(Giv	edent's Usual Occupa e kind of work done o	lurina most of workina	16b	o. Kind of Business/	Industry
7	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	du	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired	)			
7	filed w Hygier sther th ent, the	Completed by	12th			Secre			Private	2
Maryland 21215-0036	0 = 0 5	Be	17. Father's Name (First, Middle	, Last)			18. Mother's Name (First		,	
<u>ya</u>	should be nd Menta marked matic ev	ို	Clarenc	e Elmore Har			Dorothy			
<u>a</u>	2 should and Mer is marke aumatic		19a. Informant's Name/Relation				and Number or Rural Rou			
≥ .	and and a saith		Oliver Reede	r/Son	144				ellville,	
ore	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		20a. Method of Disposition 1	2 Demoval from State	20b. Place of Disp cemetery, cr	osition (Name of ematory or otherplac	ek Date	200	. Location - City or	Town, State
Ĕ	Pages nent of int: If It iry or o		4 □ Donation 5 □ Other (		Maryland	National	Mem. 6/29/0	7 L	aurel, MI	)
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Juneral Service	Licensee		22. Name and Addres			neral Hon	ne
m	e m m o		Mella I.	- Vineual V	TIL	4001 Be	enning Rd.,	NE '	Wash., D	C 20019
			23a. Part1 Inter the disease, o	or complications that cause st only on a cause on sach l	d the death. Do not e	nter the mode of dyin	g, such as cardiac or resp	iratory arrest,		Approximate Interval Between
	Physician		Immediate ause (Final disease or condition	Diabe	1 1.	THE GACT	ROINTESTI	NV (0	MP ICATION	Onset and Death
	/Medical		resulting in death)	a.	s a consequence of):	16 00	13011011011	WC CO	1 11 04 114	2
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		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):					
	uted d ansit	ij.	Cause (Disease or injury that initiated events							
Ć,	exec in an	Examiner	resulting in death) Last	Due to (or as	s a consequence of):					
Box 68760,	The law requires that the death certificate be executed tto has been signed by the attending physician and age 2 should be detached for use as the burial-transit	g		d						
89	tifica ig ph as th	edi							1	
ŏ	h cer endir use	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐Ectopic pregnancy			23d. Date of de	,
<u> </u>	deal le att	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)			Month	Day Year
P. 0	uires that the de signed by the a d be detached f	Physician/Medical	9 ☐ Unknown							
ds, I	ss tha	by F	Part II. Other significant condit		but not resulting in the	underlying cause give	en in Part I. 2			the cause of death?
r d	equire en si ould b		HYPERTE	105/0K				1 TYes	2 No 3 P	robably 4 Únknown
ပ္ထ	aw re	Completed	DESMESUT	TA			2	4a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
ď	The I	E O		•				performed	d? death?	2 □ No
ta		a)	25. Was case referred to medic	al			26. Place of Death (Che		(10)	
>		To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	tient 2 ER/Outpati	ent 3 DOA Othe	er: 4 Dursing Home	5 ☐ Residenc	e 6 ⊟Other (Spe	ecify)
0	g Physer this leral di		27. Manner of Death	28a. Date of Inj			y at 28d. [	escribe how	injury occurred	
0	Attending r death. ector: After by the fune	tio	1 Natural 5 □ Pendi 2 □ Accident invest	ing (World), D	dy /cd//		Yes 2 □ No			
Division or Vital Record	Atte	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	minod Zoe. Place of it	njury - At home, farm, s	treet, factory, office	28f. L	ocation (Stree	et and Number or R	ural Route Number,
Ö	al or s afte al Dir	Certification:	T I I I I I I I I I I I I I I I I I I I	banding, c	oto. (opcony)			ity or rouni, o	natoj	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral			ing Physician: To the bes						
X	he H in 24 he Fi plete	edical	one) 2 1	and manner s				the time, date	and place, and du	e to the oddse(s)
4	To the within 3	Σ	29b. Signature and title of gerufi	er k	. 0	29c. License	e number	29d.	Date signed (Mon	th, Day, Year)
	1		17/48 U	enalor	A	9	20989		6/2/10	37
	5		30. Name and address of perso				Da Da	(3,	1-4-11-4	11/ 2078
			ELWOOD H		1.8- 600	•	POVEK KD	4	tevere.	100.2010
	Sta		31. Date filed (Month, Day, Yea.	32. Regis	trar's Signatur					
	Registi		JUN & B 500	Deren .	10. Marie					
DHI	MH 17 Rev 1/2	001	***		0.5	RIGINAL				
					Or	UNIT				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

lane

Day

21

2007 4c. County of Death

3. Time of Death

1:50A

		,	1 - For State Registrar	State of Ma	aryland		artment rtificate			and Me		giene Reg. No.		7	50.
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month	ath Day	/ Year		Time of Death
	/Medic		HOSEY NATHAN		SON						June	23	200	7 8	8:55 P <sup>M</sup>
İ	Examin	er	4a. Facility Name (If not institution, g				4b. City, To	own, or	Location of	f Death		4c.	County of Dea	ath	
			3512 Hepburn Co  5. Social Security Number 6.		je (In yrs. last	birthday)	Burt If Under 1		ville If Under 2		8. Date of Birt	th M	lontgom		State or Foreign
	Funeral Director		239.66.7352	1⊠M 2□F	61	Yrs.		Days	Hours	Min.	(Month, Da	y, Year)	0	ountry)	
*	er, elekt erlyck		Usual Residence of Decedent		,						Feb. 2	3, 1	940 NO	ren (	Carolina
	anylar show d at	ڀ	10a. State 10b. County		10c. City, T	own or Lo	ocation		1						side City Limits
	he Mark	Directo	Maryland Montgo	nery					nsvil	.le		10.000			□Yes 2★ No
	a or 2		10e. Street and Number				10f. Zip C	Code	0006			10g. Citi	zen of What C		
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show sdical Examiner must be notified at	Funeral	3512 Hepburn Cou	12. Was Decedent	Ever in U.S.	13.	Was Decede	ent of His	2086		city Yes or No	- 1	U.S.A.  14. Race - American Indian,		
0	ifter d ir iten		1 ☐ Never Married 2 ★ Married	Armed Forces?	No					i, Puèrto P	city Yes or No ≀ican, etc.)		Black, Wh	ite, etc.	
215-0036	ours a ral", o Exan	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Vietna	m	1 ☐ Yes 2	XI No	Specify:				Specify:	Bla	ck
ဂ ဂ	72 hc 'natur dical	Completed	15. Decedent's (Specify only highest of	Education trade completed)	1	6a. Dece	dent's Usual kind of work DO NOT use	Occupa done di	tion uring most	of workin	ıg ı	16b. Ki	nd of Busines	s/Industry	
7	vithin ne. han " e Me	ldω	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT use ipment					11 6	. Posta	1 Ca	ruico
N	be filed within 72 hatal Hygiene. dother than "natuevent, the Medical	ပိ	17. Father's Name (First, Middle, La			Equ	Thuenc	<del>-</del>			(First, Middle,	L		it be	TVICE
yland		To Be	Tommie Robinse	•							e Blacl				
	3395	ř	19a. Informant's Name/Relationship		1	19b. Mailii	ng Address (	Street a	nd Numbe	r or Rural	Route Numbe	er, City o	r Town, State,	Zip Code	e)
Mar	and 2 s ealth ar n 27 Is er trau		Gail E. Robinson	ı - Spouse		3512	Hepbu	ırn	Court	, Bu	rtonsv	ille	, Maryl	and	20866
e G	of Hea		20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3	Domeyal from State	20b. Place	e of Dispo	osition (Name matory or oth	e of ner place	9)	Da	ate	20c. Lo	cation - City o	r Town, S	tate
	permit. Pages Department of I Important: If It any Injury or o		4 Donation 5 Other (Spec		Park1								ville,		
galti	permit. Depart Import any Inj once.		21. Signature of Funeral Service Lic	ensee	+.										Æ, INC.
			Non cy A.	Turcan	_ U~								er Spr	-	D 20904
		. 11	23a. Part1. Enter the dist ase, or co shock, or heart failure. List on	mplications that caused y one cause on each li	i the death. [ ne.	Do not ent	ter the mode	of dying	), such as	cardiac or	r respiratory a	rrest,		Appr Inter Onse	roximate val Between et and Death
	Physician / /Medical		Immedia use (Final disease or condition resulting in death)	a. Strok										1 y	ear
	Examiner			Due to (or as	tary A		ma c/=	ro	cocti	on				1 37	ear
18		Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as			ma 5/P	, IC.	Secti	.011				<u> </u>	<u> </u>
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events Panhypopituitarism										1 y	ear	
Ď	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequen	ce of):									
08/p0	icate b physic s the bi	dical	•	d											
	ding Se as	/Med	IF FEMALE:	23c. If yes, outcome	pf pregnancy	,							00d Date of de	liven	
Š Q	eath atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3[	☐Ectopic pre					1	23d. Date of de Month	Day	Year
	the c y the chec	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown				,							
7	law requires that the deas been signed by the 2 should be detached	by PI	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the u	nderlying cau	use give	n in Part I.		23e. Did to	obacco u	se contribute	to the cau	use of death?
cords	equire en sig ould b										10,	Yes 2	No 3□F	Probably	4 ∐Unknown
ပ္	g 25 CA	Completed									24a. Was		24b. Were a	utopsy fir	ndings available on of cause of
<u>r</u>	Tr ate pag	Con									perfo 1□ Yes	rmed?	death?	s 2 🗆 l	
Z	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	·					of Death	(Check only o	ne)			
0	Phys this al dii	To	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 ☐ Inpatie		Outpatier	nt 3 DOA		4 LI Nui		ne 5 🙀 Resid 8d. Describe I		6 ☐Other (Sp	ecify)	
0	ding Phys h. After this funeral di	tlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Da	y Year)	Injury	м	c. Injury Work 1 □ Y	?ື` ′es 2.∐.N		ou. Describe i	now injui	y occurred		
2	Atten deat sctor: by the	ertification:	3 Suicide 6 Could not	be 28e. Place of inju	ury - At home	, farm, str				-	8f. Location (S	Street an	d Number or F	Rural Rou	te Number,
5	al or s after al Dire	Certi	4 Homicide	building, et	c. (Specify)						City or Tou	vn, State	)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	of examination	dge, deat and/or in	h occurred a vestigation, i	t the tim in my op	e, date and pinion, deat	d płace, a th occurre	and due to the ed at the time,	cause(s) date and	and manner a d place, and du	s stated. Le to the d	cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c.	License	number			29d. Dai	te signed (Mor	nth, Day,	Year)
			1 Rene 1	Marie	4 CP	TM	C VA	of 1	\$ 124	1835		JUN	J 26	200	1
	12		30. Name and address of person wh	o completed cause of d	leath (Item 23	a) (Type,	Print)								
			Rene Mallory , CF	T MC, 6900	Georg	ia A	venue,	NW,	Wasi	ningt	on, Do	203	30 /		
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 7	2007 See	ar's Signature	A	and is								

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Aparles